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Quality in All Levels: A Model Defining and Measuring Quality in Bioethics Education

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QUALITY IN ALL LEVELS: A MODEL DEFINING AND MEASURING QUALITY IN BIOETHICS EDUCATION

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By

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ABSTRACT

QUALITY IN ALL LEVELS: A MODEL DEFINING AND MEASURING QUALITY IN BIOETHICS EDUCATION

By

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May 2020

Dissertation supervised by Professor Henk ten Have

Due to the lack of academic studies in the quality assessment of bioethics education, this dissertation aimed to propose a normative model, Quality in All Levels (QAL), to define and measure quality in bioethics education. The QAL model described quality in bioethics education as conformance to the goals and determined these goals as (1) increasing ethical knowledge, (2) improving ethical skills to strengthen ethical sensitivity, awareness, and judgment, (3) developing ethical behavior, and (4) promoting cultural competence. The dissertation utilized Avedis Donabedian's three approaches: structure, process, and outcome to formulate quality standards and indicators in bioethics education. In respect of data collection, QAL suggested using mixed research methods and different data collection techniques, such as document reviews, surveys, interviews, and observations. Additionally, QAL advised employing a Likert scale-based method

with an analytic hierarchy process in order to analyze data and reach a conclusion concerning the overall quality of a bioethics program or course. QAL assumes that it is not possible to ensure long-standing, deliberate, and sustainable quality without simultaneously fulfilling certain standards in each level of bioethics education. In this view, QAL regards the structure, process, and outcome as the three levels of bioethics education and requires attributing equal importance to all these levels.

Even though encompassing some limitations due to its normative aspect, the QAL model has high potential to fill the gap in the intersection of bioethics education and quality by indicating the first comprehensive study defining and assessing quality in this emerging field. Furthermore, the emphasis of the model on promoting cultural competence inquires the feasibility of reconciling differences in bioethics and integrating distinct values without causing assimilation or marginalization.

DEDICATION

To my dear wife, Muberra, and sweetheart children, Baran and Hamza

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LIST OF ABBREVIATIONS

AHP	Analytic Hierarchy Process
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
APA	American Psychological Association
ASBH	American Society for Bioethics and Humanities
COMEST	World Commission on Ethics of Scientific and Knowledge and Technology
GEObs	Global Ethics Observatory
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NICE	National Institute for Health and Care Excellence
RBF	Results-based Financing
QAL	Quality in All Levels
TDR	Three-degree Ranking
TQM	Total Quality Management
UDBHR	Universal Declaration on Bioethics and Humana Rights
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

1 Chapter - Introduction

The historical background of medical ethics reveals that medicine has been practiced with some ethical rules and principles since the time of Hippocrates. From the Hippocratic Oath to Galen ethics, from Galen ethics to Thomas Percival's medical ethics, and then to the American Medical Association's code of ethics, medical ethics has had major changes and has represented different perspectives in each stage of history. However, the most influential change in medical ethics occurred with the emergence of bioethics in the 1970s. In this view, the birth of bioethics can be considered a paradigm shift in medical ethics, rather than a change; not only because of the respect for the person- and justice-driven characteristics of bioethics, but also due to its broader scope which transcends medicine and encompasses many other disciplines including biology, public health, and environmental sciences.

The misuse of medical knowledge during and after World War II, through research with human subjects, such as the Nazi doctors' experiments and Tuskegee Syphilis Study, prompted national and international authorities to take certain measures to avoid such savage violations. The Nuremberg Code in 1947, the Universal Declaration of Human Rights in 1948, and the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1974 are some examples of this effort aiming to draw up a legal and ethical framework to protect human dignity and rights as well as prevent human beings from abuses including human subjects research- and medical practices-related misconducts. In this context, the Universal Declaration on Bioethics and Human Rights (UDBHR) in 2005 is the most comprehensive international

engagement in bioethical matters. The UDBHR determines and promotes various principles to achieve and disseminate respect for human dignity and human rights, equality, justice, cultural diversity, international cooperation, and social responsibility.

In addition to the brutal experiments, medical, technological, and pharmaceutical improvements, liberal policies, and political as well as judicial involvement in ethical issues accelerated the emergence of bioethics as a new discipline and led to a remarkable growth in this academic field. Developments in the bioethics field have positively influenced the teaching of bioethics as well. The shortage of bioethics education and academic works at the beginning of the 1970s has been succeeded by the outstanding progress in the last five decades. The number of bioethics and applied ethics institutions across the world, which is demonstrated by the United Nations Educational, Scientific and Cultural Organization's (UNESCO) Global Ethics Observatory, proves that bioethics teaching is a worldwide phenomenon. However, even though today's bioethics has an enormous amount of literature with numerous academic institutions, journals, and bioethicists, it is difficult to reach a consensus on the content, method, and approach of teaching bioethics. Furthermore, in the case of gauging the effectiveness of bioethics programs, there is a lack of academic studies to define quality in bioethics education and measure the quality of existing bioethics programs. From this perspective, this dissertation aims to fill this gap by defining quality in bioethics education and suggesting a model to measure quality in bioethics teaching. The dissertation focuses on the concept of quality, defines it in accordance with the major features of bioethics education, determines specific quality standards and indicators, and explains how to measure the quality indicators of bioethics education.

The dissertation develops its analysis in light of the following chapters. The introduction (chapter 1) reflects on an overall outlook for the general framework of the dissertation. Chapter 2 provides a literature review on ethics education in order to explore the current situation of existing ethics programs and benefit from their experience. Chapter 3 addresses a short historical background of the emergence of bioethics and bioethics education. Chapter 4 evaluates some pertinent concepts, such as ethics, education, and ethics education and determines the goals of bioethics education. Chapter 5 examines the term *quality* by considering the perception of some other fields in order to describe quality in bioethics education. Chapter 6 pinpoints quality standards and indicators in bioethics education to demonstrate measurable criteria in teaching bioethics. Chapter 7 clarifies the data collection and analysis methods for measuring the indicators. The conclusion (chapter 8) provides an overview of the chapters and summarizes the running of the model to show how it gauges the quality of bioethics education.

1.1 Learning from Experiences to Determine Quality in Ethics Education

This dissertation aims to develop a model to evaluate the quality of bioethics programs. However, prior to outlining the general structure of the model, it may be beneficial to inquire about recent studies in ethics education to see their interest in quality. In this context, the aim of this chapter is to review the literature on ethics education to understand whether it is possible to explore some indications of what quality in ethics education is. The study reviews the literature by focusing on the ethics programs' teaching scope, teaching method, and classroom model in light of students' and educators' perception, the performance of the programs, and the effectiveness of the programs. The relevant data was obtained by utilizing Duquesne University Gumberg

Library's Discovery System-Quick Search that consists of about 20 databases including CINAHL, ERIC, PsycINFO, and Scopus®. The research was limited to 6 years from 2010 to 2015 inclusive.

In regard to teaching scope, the findings indicate that nineteen studies address certain issues about constituting an ethics curriculum, the basic features of content, and teaching hours. The most emphasized matter is the need for creating a convenient and applicable ethics curriculum. Six studies underscore the importance and necessity of generating a curriculum encompassing and demonstrating all the relevant subjects that are supposed to be taught. The content of the ethics programs is another point frequently highlighted. Contrary to the general assumption that the teaching of ethical theories is not supported, 6 studies, four of which are about nursing programs, underpin the learning of ethical theories. These studies demonstrate an explicit demand for teaching theories with ethical principles and codes. The teaching of ethical principles and professional codes are also welcomed by both educators and students. The demand for learning ethical principles and codes is much clearer in nursing and psychology than the other academic fields. However, the studies do not reveal a lucid picture about ethics program hours to draw a conclusion. Merely three articles touch on the hours of ethics teaching, and even these three studies show a wide range of hours between 4 hours and 32 hours.

In respect of the teaching method of ethics, the studies largely illustrate the implementation or recommendation of lectures (7 studies), case-based teaching (7 studies), group discussions (5 studies), and assigned readings (3). In other words, even though educators' and students' approaches toward teaching methods differ slightly

among distinct studies, lecture type, case-based teaching, and group discussions are the most applied or demanded methods.

Although there is an obvious request for increasing numbers of ethics-related courses and course hours, there is not a consensus on the classroom model of ethics education. Some educators and students are proponents of having separate ethics courses, whereas some others support the integration of ethics into the whole curriculum. The issue of whether having face-to-face ethics courses or online courses is another subject of the classroom model. At that point, instead of asserting an alternative to a classical classroom system, some studies recommend online sources as supplementary to reinforce existing ethics education.

Regarding the perception of educators and students, the studies explicitly indicate two points. The first one is that educators and students admit that ethics teaching positively influence students' ethical awareness, knowledge, and reasoning. They also believe that more ethics education should be provided to enhance students' ethical understanding. The second point is that despite not rejecting lectures and teaching of ethical theories, students tend to learn tangible ethical norms, codes, and principles to be able to apply them to their professional practices.

The performance of the current programs indicates how well the programs work. However, as the studies reveal that even some medical and nursing programs still do not offer formal and separate ethics courses, or the existing ethics teaching is unstructured in these programs. Furthermore, the studies point out several barriers that diminish the performance of ethics teaching. Limited time is one of these obstacles. Additionally, the shortage of educators and the lack of educators' experience in ethics education are also

impediments affecting the performance of ethics teaching. Additionally, limited resources, unstructured curricula, and crowded curricula are some other handicaps of ethics education underscored by the studies.

Effectiveness refers to the results of an implemented ethics program. The majority of the studies (18 studies) highlight the effectiveness or ineffectiveness of certain parts of the ethics programs. Fifteen studies find that ethics education significantly increase students' ethical awareness, reasoning, sensitivity, judgment, knowledge, perspective, and personal values. Nevertheless, when it comes to the question of which teaching style is more effective, it is difficult to encounter a consensus. The studies clearly show that although there are several shortcomings and impediments influencing the performance of ethics programs, ethics education carries the high potential to produce promising outcomes. To improve the current situation, more ethics education with well-established curricula is needed. However, this does not only mean to increase the number of ethics courses and hours, but also it necessitates structural changes.[1]

In respect of quality, the reviewed studies do not provide a clear picture to outline a general framework. In other words, due to inadequate emphasis on quality, the studies do not give the opportunity to figure out what quality in ethics education is. Nonetheless, the studies reveal students' and educators' perceptions and expectations about ethics education as well as the performance, benefits, shortages, and shortcomings of the current ethics programs. These findings can be utilized when elaborating the concept and content of quality in bioethics education. Identifying the current situation, determining the stakeholders' needs, perceptions, and expectations, and specifying present challenges in

ethics education would supply invaluable indications to elucidate quality in this specific area.

1.2 A Short History of the Emergence of Bioethics and Bioethics Education

Albert R. Jonsen accepts bioethics as the "newer version" of medical ethics.[2] However, Jonsen does not elaborates the primary features of the old and new versions; he merely considers the difference a progression in medical ethics.[3] Nevertheless, it is possible to find some clues regarding the changes in the history of medical ethics from Beauchamp and Childress' analysis that the alteration between the old and new versions resulted from the deficiency of the Hippocratic tradition in contemporary issues, such as privacy, informed consent, and research with human subjects.[4] On the other hand, as Jonsen underlines in *The Birth of Bioethics*, bioethics-emerging factors did not appear "with a Big Bang."[5] Therefore, for a better insight into bioethics and bioethics education, the historical background of medical ethics and developments in bioethics education should be examined. From this perspective, the aim of the third chapter is to concisely look at the history of bioethics and the progress in bioethics education to demonstrate the evolution of medical ethics and its teaching. The chapter begins with assessing the pre-bioethics period by briefly examining the Hippocratic Oath, Galen ethics, and Thomas Percival's approach. In the second section, the chapter debates the discovery of the term *bioethics* and its development. In the last section of the chapter, the emergence of bioethics education is assessed, and the contribution of the Hastings Center's *Report of the Commission on the Teaching of Bioethics (The Teaching of Bioethics)*, UNESCO's *Bioethics Core Curriculum*, and the Presidential Commission for the Study of Bioethical Issues' *Bioethics for Every Generation* to bioethics teaching is underscored.

The Hippocratic Oath is a document addressing certain moral stances in practicing medicine. The Oath's estimated date of birth is about 400 BCE. The only fact we know about the Oath is that it is an ancient Greek script. The Oath promises eight commitments, some of which require positive obligations as to do something, and some other contain negative obligations to avoid doing something.[6] Different arguments are available with respect to the role and value of the Oath in the history of medical ethics. However, despite its religious, paternalistic, and absolutistic characteristics, the Oath carries a profound significance in medical ethics. The most critical point in the judgment of the Oath is to evaluate, recognize, appreciate its value by assessing it with the period when it was formed, rather than with the contemporary ethical standards. From this perspective, the Oath is the first available script articulating the ethical framework of practicing medicine.

Roman physician Galen's philosophy is another essential contribution to the historical development of medical ethics. Galen reinterpreted the Hippocratic tradition by focusing on "a decorum ethics, stressing attitudes and virtues rather than rules and duties."[7] According to Galen, physicians must learn the logical, physical, and ethical parts of philosophy in order to practice medicine like the Hippocrates.[8] The comparison between the Hippocratic Oath and Galen's approach shows that the Oath indicates a deontological perspective requiring compliance with certain obligations, while Galen's philosophy relies on the idea of virtuous physicians.

The post-Galen time was a silent period for medical ethics for many centuries. In the 18th century, two British physicians' works created a new phase in medical ethics.[9] John Gregory and Thomas Percival are two pioneers transforming medical ethical into

medical professionalism and paving the way for the establishment of the *Code of Medical Ethics* of the American Medical Association (AMA).[10] Thomas Percival's work *Medical Ethics* is the first source in the literature using the term *medical ethics*.[11] In this study, Percival proposes certain professional standards regarding the relationship among physicians and the physician's behavior toward patients and the public.[12] In this context, it is possible to argue that Percival launched a medical professionalism-driven ethics.

The Hippocratic Oath requires physicians to comply with specific rules, whereas Galen ethics encourages physicians to gain certain knowledge and skills to be able to perform medicine in the way the physicians in the Hippocratic era did without naming these moral frameworks as medical ethics. However, Thomas Percival is the first person directly utilizing the term *medical ethics* to elucidate physicians and surgeons' professional conduct. The AMA's *Code of Medical Ethics* of 1847 and the subsequent versions facilitated and embraced the utilization of the term *medical ethics*. However, at the beginning of the 1970s, some scholars began using a new concept, *bioethics*, instead of *medical ethics*. This change was not merely a conceptual modification, but also a contextual paradigm shift.

The issue of deciding who coined the term *bioethics* is a contentious matter. Although the debate intensifies around the name of Van Rensselaer Potter, Sargent Shriver, Andre Hellegers, and Fritz Jahr, the historical sequence of the relevant publications and events shows that it is German Protestant pastor and ethicist Fritz Jahr who first time utilized the word *bioethics* in German in 1927, and Van Rensselaer Potter is the first person who used the term *bioethics* in English in 1970.[13] Nevertheless, Jahr's first-time utilization of the term in 1927 does not require overlooking the role and

influence of Van Rensselaer Potter, Sargent Shriver, and Andre Hellegers in the foundation and development of bioethics at the beginning of 1970s. Potter's studies including his book *Bioethics: Bridge to the Future* and the effort of the founders of the Kennedy Institute of Ethics including Sargent Shriver and Andre Hellegers paved the way for the emergence and development of bioethics as a new multidisciplinary field.

In the case of examining the literature to explore the concept and content of bioethics, it is possible to encounter three common conclusions regarding the features of bioethics: bioethics is a new discipline; bioethics is a multidisciplinary field; and technological, social, political, and cultural changes in post-World War II period urged the emergence of bioethics.[14] However, the accuracy of these statements depends on how to analyze these points. Accepting bioethics as a new discipline is meaningful, but also an inadequate approach. It is meaningful because it manifests the study of morality not only in medicine, but also in all health-related areas including public health, health research, and environmental sciences. This approach is inadequate because bioethics is not a completely newly-discovered discipline, but an evolution of medical ethics.

The matter of being a multidisciplinary field is the second statement about the primary characteristics of bioethics. Like the previous point, this issue also necessitates appraising the relationship between medical ethics and bioethics. There is no doubt that bioethics is associated with several academic fields. However, medical ethics has been a multidisciplinary study as well since the time of Hippocrates. Galen's stance on the physicians' knowledge is one of the best examples to prove the multidisciplinary function of medical ethics. Galen requested physicians not only obtaining medical knowledge but also learning philosophy and acquiring the knowledge of all relevant disciplines

including astronomy, biology, and psychology, by expressing the necessity of knowing "the logical, the physical, and the ethical" parts of philosophy.[15]

The third agreement is related to the conditions that spurred the emergence of bioethics. The medical, technological, legal, social, and political problems and changes, particularly in the post-World War II period, brought about the need for a new freedom-, justice-, and equity-based approach in medicine, research, and public health.[16] Nevertheless, like the other two statements, the circumstances led to the emergence of bioethics should be assessed with the historical development of medical ethics, which may be regarded as an evolutionary process. Additionally, it is feasible to acknowledge that the post-World War II incidents, discoveries, and challenges accelerated the pace of this evolution. However, it is difficult to be convinced that bioethics would have flourished in such a short period without the contribution of the previous phases of medical ethics including the ethics of Hippocrates, Galen ethics, and Percival ethics.

In respect of bioethics education, Robert M. Arnold and Lachlan Forrow assert that medical ethics has been taught since the first day of the teaching of medicine as an "apprenticeship model."[17] Furthermore, according to Albert R. Jonsen, in the 19th century, many medical curricula were encompassing some lectures to teach the moral responsibilities of physicians.[18] Nevertheless, as many scholars highlight, the systematic teaching of ethics in medical schools just goes back to the 1970s. The survey of the Hastings Center (1976) illustrates that ethics education in medical schools remarkably increased in the 1980s and 1990s.[19] Additionally, a data analysis-based study done by Lisa M. Lee and Frances A. McCarty demonstrates that bioethics education in postsecondary degrees has recently boosted.[20] From this perspective, it is possible to state

that not only bioethics, but also bioethics education has bloomed in the last few decades through the effort of individual scholars, local and national institutions such as the Hastings Center and the Kennedy Institute, and international organizations like United Nations Educational, Scientific and Cultural Organization (UNESCO).

The Hastings Center's report of 1976, *The Teaching of Bioethics,* is the first comprehensive study devoted to bioethics teaching. The report was prepared by the commission of 9 distinguished scholars from different institutions and different disciplines. The report aimed to provide all stakeholders with a guideline regarding the teaching methods, content, evaluation, and materials of bioethics education. Under the circumstance of the 1970s, in terms of the lack of experience, sources, and guidelines in the teaching of bioethics, the report filled a major gap by producing specific information concerning the goals, patterns, and structure of bioethics teaching.[21]

UNESCO's *Bioethics Core Curriculum* is another invaluable source facilitating the dissemination of bioethics education at the international level. The first section of the Curriculum, which gives a sample syllabus, was published in 2008. Although it can be benefited by everyone, its primary target group is the areas where there is a lack of teaching experience in bioethics education.[22] The second section of the Curriculum, which identifies study materials, was published in 2011. This section is the complementary part of the syllabus which addresses specific methods and sources about the teaching of the topics taking part in the syllabus.[23]

The third work on bioethics education is *Bioethics for Every Generations* produced by the Presidential Commission for the Study of Bioethical Issues and published in 2016. *Bioethics for Every Generation* contains eight recommendations "to

increase and improve the use of democratic deliberation and ethics education in order to enhance complex decision making in bioethics and health, science, and technology policy at all levels."[24] Even though, in comparison with the other two works, the report does not yield sufficient practical details regarding bioethics teaching, the presence of such a report and its recommendations about guiding, supporting, and developing bioethics education are crucial to attract public and scholarly attention to this area.

1.3 Determining the Goals of Ethics Education

Determining the goals of bioethics education has pivotal importance in the systematics of this dissertation. This effort would not only allow us to declare how we interpret the teaching of bioethics, but also give us some clues about our perception of quality in bioethics education. In this view, the fourth chapter aims to draw a general framework regarding the goals of bioethics education from a normative perspective. Prior to concentrating of the goals, the chapter clarifies the concepts of ethics and education to specify what these terms imply. In the second section, the chapter sheds light on the notion of ethics education and elaborates Kohlberg's cognitive-developmental approach, Handelsman et al.'s ethical acculturation model, and the Delors Report's learning throughout life concept to benefit from these works when forming the goals of bioethics education. Due to the significance attributed to cultural competence, as a goal of bioethics education, the chapter also analyzes the concept of cultural competence and investigates the possibility of creating a common ground to reconcile ethical issues in today's multicultural societies.

Many studies discuss the relationship between morality and ethics, and some of them regard these terms as interchangeable.[25] However, this chapter differentiates ethics

from morality by pinpointing certain distinctions between these two terms. From this perspective, morality is defined as a combination of rules, values, and standards shaping the rightness and wrongness of individual and social conduct, whereas ethics is described as the study analyzing moral standards and values to determine what is morally right and wrong and providing answers to the questions: "How should I/we live and why?" as well as "What should I/we do and why?" in light of the aim of minimizing evil and maximizing good.

Even though education is accepted as the best way to promote individual and communal development as well as the most effective remedy for overcoming numerous problems, such as ignorance, disparity, and poverty, the success of education chiefly depends on its good practices.[26] Moreover, education encompasses two different aspects: teaching and learning. Teaching refers to the effort of a teacher who provides learners with the knowledge of something. Learning is the other aspect of education requiring learners to obtain certain knowledge and skills.[27] This situation means that desirable educational outcomes also depends on a mutual endeavor, relationship, and readiness between the teacher and learner. The World Bank considers education an effective tool to ensure economic growth, peace, and stability as well as to reduce poverty, gender inequality, and economic disparity.[28] On the other hand, the United Nations Educational, Scientific and Cultural Organization (UNESCO) accentuates the humanistic aspect of education to strengthen "respect for democracy, human rights, social justice, cultural diversity, gender equality and environmental sustainability."[29]

The Delors Report (*Learning: The Treasure Within*), a publication of UNESCO, is an essential source portraying the view of UNESCO on education. The Report

announces its vision through four pillars: Learning to know, learning to do, learning to live together, and learning to be. *Learning to know* demands the acquisition of knowledge of different subjects according to scientific, economic, and social necessities. *Learning to do* is about attaining relevant skills for doing a job. *Learning to live together* is related to the recognition of historical, cultural, and religious values of individuals, groups, and nations and the requirement to develop appropriate methods to administer problems and differences in a peaceful manner. *Learning to be* pays attention to the exploration and utilization of personal capabilities.[30] Due to the all-inclusive approach of the Delors Report to elaborate education and its emphasis on embracing cultural, religious, and political differences, this chapter interprets education in light of these four pillars.

In respect of ethics education, there are two issues need to be specified: whether individual behaviors can be changed through ethics education and how ethics should be taught. According to Gordijn and ten Have, ethics education cannot guarantee virtuous conduct per se. However, they believe that this premise does not discredit the value and necessity of teaching ethics.[31] Furthermore, the literature review done by Michael Wright could not find adequate evidence that ethics education improves individuals' moral conduct.[32] Therefore, it should be acknowledged that the positive influence of ethics education on ethical behavior has not been proved in a manner to persuade everyone that the teaching of ethics creates individuals with higher moral standards in their behaviors. However, the expectation of changing an adult person's behaviors through ethics education brings some other challenges, such as why we desire such changes and what differs the teaching of ethics from the teaching of any other subjects.

Bayard L. Catron claims that the teaching of ethics is not different from the teaching of other subjects, and considers teaching ethics as conveying the knowledge of ethics and likens the role of ethics professors to retailers selling knowledge.[33] Additionally, according to Max Weber, there is no distinction between a teacher's effort and a greengrocer's work because the teacher sells knowledge, whereas the greengrocer sells cabbage. If we do not have any expectation for greengrocer's character, but providing us good cabbage, we should not expect teachers to be leaders in their fields.[34] In this context, an ethicist or a professor in ethics is merely a person selling his/her knowledge, like other professors in other academic disciplines. Having the expectation for the ethicist's moral conduct in his/her daily life may not be realistic. In other words, the expertise in the knowledge of ethics does not ensure moral conduct by itself. Therefore, ethics may be taught like any other academic subject, as long as its unique requirements (if available) are taken into consideration.

On the other than, the matter of whether education should instill an exact moral character is an essential question that needs to also be answered in the case of ethics education. Darcia Narvaez examines two major approaches in ethics education: traditional character education and rational moral education, and proposes a third approach as integrative ethical education in the moral development of children.[35] Traditional character education aims to instill in children specific moral norms that may come from the family, school, church, or state's moral values.[36] Rational moral education, which is also known as the cognitive-developmental approach, intends to teach individuals how to establish good moral character without imposing a definite morality. The former view reflects an authoritarian approach by directly shaping the character with

particular moral values, while the latter approach merely pays attention to moral development. In this view, traditional character education may be called as a character-shaping approach, while rational moral education could be called a character-developing approach.[37]

Handelsman, Gottlieb, and Knapp suggest another approach about teaching ethics as ethical acculturation, which is adapted from John W. Berry's acculturation concept. According to Handelsman and his colleagues, the process of the ethics learning of psychologists is similar to the reactions of a person encountering a new culture.[38] The ethical acculturation model regards ethics training as a complicated process more than teaching or learning ethical norms. Ethical acculturation has four strategies according to the relationship between maintenance and contact: integration, marginalization, assimilation, and separation. The ethical acculturation model recognizes integration as the most desirable and ideal situation because this model aims to integrate individuals' preexisting personal and professional identities into new professional rules, principles, and values. Nevertheless, the possibility of achieving integration relies on the number of similarities or distinctions between the previous personal values and new professional culture. As Gottlieb and his colleagues underscore, in the case of too much of the gap between personal and professional cultures, some students may apply the strategy of assimilation in order to accommodate themselves to the new professional qualifications. For alleviating the transition-related challenges, Gottlieb et. al. recommend establishing a system to detect integration-related programs as well as the students' eagerness and capability for integration in advance.[39]

Bashe et al. list the benefits of the ethical acculturation model under four items: highlighting the importance of ethics in professional identity and the essentiality of refurbishing ethics knowledge; recognizing the worthiness of personal experiences and values: giving individuals the opportunity to create a balance between their personal virtues and professional standards; and representing a journey starting by identifying personal values and professional needs and ending by integrating personal and professional identities.[40]

In light of these advantages and the comparison between traditional character education and the ethical acculturation model, it can be stated that in regard to proposing a model for bioethics education, the latter model has the superiority over the former approach because the ethical acculturation requires integrating personal values into professional identity without causing marginalization, assimilation, or separation. Additionally, the individual autonomy-promoting of rational moral education may be integrated into the ethical acculturation model to forming a new model for teaching bioethics.[41]

In this view, in this chapter, ethics education is deemed as an ongoing process improving the learner's ethical knowledge and skills as well as enhancing the learner's ethical cognitive development in a manner integrating the learner's preexisting moral values with new professional ethics standards. In other words, ethics education should not impose a specific morality on learners; it should teach the learners the relevant ethical theories, norms, and principles to allow them to understand how to think critically and make ethical assessments and autonomous decisions in their professional practices.[42] For this reason, the effectiveness of ethics education should be measured through the learners'

ethical awareness, ethical analysis, and moral judgment in professional implementations, rather than their behaviors and activities out of their professional lives.

Under all these interpretations and in light of Kohlberg's cognitive-developmental approach, Handelsman et al.'s ethical acculturation model, and the Delors Report's learning throughout life concept, the goals of bioethics education are formulated as increasing ethical knowledge (learning to know), improving ethical skills to strengthen ethical sensitivity, awareness, and judgment (learning to do), developing ethical behavior (learning to be), and promoting cultural competence (learning to live together).

Increasing ethical knowledge as learning to know refers to the acquisition of ethical knowledge in order to identify, analyze, and resolve ethical issues and conflicts. *Improving ethical skills to strengthen ethical sensitivity, awareness, and judgment as learning to do* requires the transformation of ethical knowledge into ethical skills. As Jensen and Greenfield as well as Mihyun Park et al. accentuate, not only the improvement of ethical knowledge, but also the development of ethical skills is an indispensable goal of ethics education to enhance learners' ethical sensitivity, awareness, and judgment.[43] *Improving ethical behavior as learning to be* is built on the idea that it may be impossible to create a virtuous character, but it is feasible to influence a person's professional behaviors through ethics education. Furthermore, in terms of learning to be, this third goal aims to provide individuals with the opportunity to strengthen their personalities and discover their potentials. *Promoting cultural competence as learning to live together* means to raise awareness about cultural, religious, and social diversity in healthcare, and explore a peaceful way for individuals (healthcare stakeholders) to be

able live together in a multicultural society without cultural assimilation, separation, or marginalization.

The first three goals mentioned above can be evaluated as traditional goals of bioethics education because they have been stated by many sources. However, the cultural competence-based fourth goal is the unique characteristic of this present study. Of course, the concept of cultural competence or underlining its significance is not a new idea in bioethics. Nevertheless, considering it a goal of bioethics education as the way to recognize and respect differences is a novel approach. Cultural competence requires being cognizant of cultural differences and creating a reconcilable cross-cultural environment. Nevertheless, certain issues in bioethics, such as abortion, especially culture- or religion-oriented ones, do not encompass any flexibility for a compromise. However, even in the case of such challenges, ethicists should continue looking for an available common ethical ground for multicultural societies in order to be able to live together.

Despite the presence of numerous views on cultural and religious differences and their various impacts on bioethical issues and individual autonomy, it is an obligation to recognize today's religious and cultural diversity and the reality of its consequences. Furthermore, it is obvious that it is not only infeasible to ignore the existing cultural and religious diversity, but also it is immoral to intend to eradicate this variety. For this reason, our intention and purpose should be to generate a harmonious togetherness and prevent individuals and communities from external and internal pressures against their cultural and religious values that do not harm others.

Beauchamp and Childress assess morality as common morality and particular morality. Universally accepted moral norms, such as not to lie and not to kill, represent common morality. On the other hand, moral norms recognized merely by specific persons, groups, or communities, such as not to abort, illustrate particular morality.[44] Gert and his colleagues also focus on common morality and assert that there are some universal moral norms that are valid and operative everywhere in every culture, religion, and society.[45] Robert M. Veatch is another scholar works on the idea of common morality. However, Veatch names his viewpoint on this concept as *convergence hypothesis* and suggests flexibility and human fallibility, even in the understanding of religion-driven ethical matters.[46] Veatch also points out the *Universal Declaration on Bioethics and Human Rights* to prove the possibility of creating a consensus on certain ethical values and principles.[47] Moreover, Leigh Turner underlines the role of international organizations to find a common ground to establish a global culture on bioethical challenges.[48]

As a result, a common ground and reconciliation regarding cultural and religious differences can be achieved through the involvement of all parties and stakeholders in the pertinent discussions. Additionally, instead of wasting all the effort on a limited number of conflicts, paying attention to common moral values would enable us to build a consensus on various ethical problems.[49]

1.4 Defining Quality in Bioethics Education

Quality is an alluring word utilized to indicate the best features or practices of a product or a service. Even though quality is a term overly used in daily life and academic papers, its meaning largely relies on the user's insight or interpretation. Despite such a

difficulty, many academic fields have studied the concept of quality to decide the definition and components of this term. However, the available studies in bioethics education do not provide adequate evidence to directly outline a definition of quality in this specific academic area.[50] Nevertheless, drawing a definition of quality in bioethics education is an essential step in respect of the purpose of this dissertation and the construction of the next chapters. Therefore, the aim of this chapter is to examine the understanding of quality in some relevant fields in order to define quality in bioethics education. In the first section of the chapter, the definition of quality and its value is expounded to specify the contextual acumen and significance of studying quality. The second section elaborates quality in education and healthcare to reflect the understanding of quality in these two pertinent areas. The last section inquires the need for a description of quality in bioethics education and proposes a definition by benefitting from the approaches illuminated in the previous sections.

In general, quality is explained as the degree of excellence. However, according to Geoffrey D. Doherty, this approach means nothing, but a subjective statement because excellence does not illustrate any objective judgment.[51] Several scholars, such as Philip B. Crosby, pay attention to the challenges about defining and specifying quality.[52] One of the primary agreements on this term is that quality is a contentious and multidimensional concept. Nevertheless, this situation has not prevented academic works from formulating different definitions of quality. For instance, J. M. Juran defines quality as "fitness for use."[53] Furthermore, Philip B. Crosby describes quality as "conformance to requirements.[54] On the other hand, David A. Garvin classifies quality-related descriptions into five categories: transcendent; product-based; user-based; manufacturing-based; and

value-based definitions.[55] However, Garvin reaches the conclusion that none of these five categories demonstrates an adequate and appropriate framework to thoroughly elucidate quality per se and recommends the eight-dimension approach to detail the notion of quality.[56]

In regard to the historical background and development of this attractive, but also contentious concept, Tirupathi R. Chandrupatla asserts that the history of quality goes back to the beginning of human civilization.[57] Albert Weckenmann and his colleagues study the developments in quality management through four paradigms: quality inspection, process quality, system quality, and total quality management.[58] According to Weckenmann et. al., the current situation of quality management also requires "the consideration of social responsibility and sustainability."[59] This viewpoint indicates that quality is no longer solely a concern of an organization or limited to an organization's internal interest; quality management is also an essential element in social, economic, and environmental sustainability. From this perspective, it is feasible to regard this approach as the fifth paradigm in quality management because of its alteration from the organization to the society.

Quality has a positive connotation to convince people that the product or service meets their needs and expectations. In this view, attracting new customers and satisfying current customers may be considered a main reason to focus on quality in different industries. Moreover, as Chuck Chakrapani emphasizes, quality management aims to maximize efficiency and minimize costs.[60] Therefore, increasing efficiency and customer satisfaction as well as reducing costs are some outcomes expected from quality.

However, especially the issue of customer satisfaction brings certain complexities in some areas like healthcare and education.[61]

Customer satisfaction requires fulfilling the expectations of the customer. In light of a customer satisfaction-driven approach, in the case of accepting a student as the customer in education, the educational activities need to be produced in accordance with the student's expectations. This situation implicitly assumes that the student is capable to determine what he/she needs and knows how the educational activities should be produced and provided. However, as W. Edwards Deming highlights, in such a system, it is possible to encounter some talented professors and teachers who are underrated or professors and teachers with the lack of academic qualifications who are overrated by students.[62] For this reason, the concept of customer and customer satisfaction-oriented quality evaluation may arise various discussions and problems in healthcare and education.

Quality in education has been a very hot topic since the late 1980s and early 1990s. Scholarly activities, like the Journal of *Quality in Higher Education* as well as regional endeavors, such as the Bologna Process and the MERCOSUR Accreditation Scheme have created the opportunity to debate the concept of quality in education. Furthermore, as international organizations, the United Nations Educational, Scientific, and Cultural Organization (UNESCO) and the World Bank have concentrated on the effort supporting and promoting quality in education.[63] Moreover, the Incheon Declaration of 2015 acknowledged quality as a fundamental component of education to fulfill the expected goals.[64]

Scholarly works evaluating quality in education commonly underscore W. Edwards Deming's, Joseph M. Juran's, and Philip B. Crosby's quality definitions and benefit from these scholars' views.[65] At that point, the question about whether the definitions, approaches, and models of the business industry concerning quality can be implemented to education comes out. Nevertheless, there is a general acceptance about this issue that regardless of the focuses and requirements of different fields on quality, ensuring and maintaining the effectiveness and efficiency of the products, activities, and services according to the predetermined goals are the common ground for all fields. For this reason, despite certain distinctions, different academic fields can contribute to each other to form their own approaches on quality with their peculiarities.

Lee Harvey and Diana Green categorize all the understandings of quality in education into five classifications: quality as exceptional; perfection or consistency; fitness for purpose; value for money; and transformation. After assessing these quality approaches, Harvey and Green draw some conclusions regarding defining quality in education: firstly, different stakeholders of higher education have different goals, interests, and perceptions; secondly, a unique quality definition cannot satisfy the goals, interests, and perceptions of all these parties; and finally, not a quality, but qualities should be defined to meet the expectations of all the stakeholders.[66]

Yin Cheong Cheng and Wai Ming Tam follow a similar method to examine quality in education. Cheng and Tam specify quality models as goal and specification model, resource-input model, process model, satisfaction model, legitimacy model, absence of problem model, and organizational learning model. According to Cheng and Tam, due to certain strengths and weaknesses, none of the models has the potential to

adequately and thoroughly address quality by itself. For this reason, the basic foundations of all these models should be employed to shape the concept of quality.[67]

Quality is an important concept in the healthcare industry as well. The literature demonstrates that quality in healthcare is chiefly structured through Avedis Donabedian's views.[68] Instead of giving a direct definition, Donabedian lists seven components of quality: efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy, and equity.[69] The Institute of Medicine (IOM) as well as the World Health Organization (WHO) reflects Donabedian's approach by providing certain dimensions to define, analyze, and evaluate quality in healthcare.[70] It seems that the IOM benefited from Donabedian's views, and the WHO utilized the IOM's stance with very slight changes to clarify quality in healthcare. Even though the IOM depicts the dimensions of quality as safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity, there is not a significant difference between their and Donabedian's insight into quality.[71] However, these distinct works prove that because of various aspect of this field, it is not simple to describe quality in healthcare through a general statement without pointing out the relevant quality components.

The history of medicine illustrates that healthcare services have been provided in accordance with certain moral norms since the time of Hippocrates. However, by the 1970s, a new term, *bioethics*, emerged with its priority to the patient's autonomy and the patient's involvement in decision-making processes. The development of bioethics has also brought about a remarkable growth in bioethics education as well in the last few decades. In this context, bioethics education is an emerging field with its unique objectives. The exclusive goals of bioethics education as well as the significance of goals

in defining quality necessitate distinguishing bioethics education from education and evaluating quality in bioethics education according to the specifications of this new field. In other words, the particular objectives of bioethics education demand drawing a particular framework for quality in bioethics education.

Quality in bioethics education can be appraised according to Harvey and Green's five quality definitions. However, quality as fitness for purpose, quality as transformation, and quality as effectiveness in achieving institutional goals are the most relevant definitions to investigate quality in bioethics education.[72] Quality as fitness for purpose is associated with customer specification and institutional mission. Customer specification demands meeting the customer's requirements, and institutional mission requires fulfilling the provider's goals. Quality as transformation considers education as an ongoing transformative process to enhance students' or participants' knowledge, skills, and abilities as well as empower students or participants to engage in the relevant processes.[73] Quality as effectiveness in achieving institutional goals puts emphasis on institutional missions, purposes, or goals.[74]

Combining these three approaches can give the opportunity to define bioethics education as an ongoing transformative process to fulfill its goals. In the third chapter, the goals of bioethics education are clarified as increasing ethical knowledge, improving ethical skills, developing ethical behavior, and promoting cultural competence. From this perspective, quality in bioethics education can be described as conformance to the goals, which denotes a functional, definite, and objective definition. This definition is functional because it indicates certain practical purposes, such as increasing ethical knowledge; it is definite because it is established on specific goals, like improving ethical skills to

strengthen ethical sensitivity, awareness, and judgment; and it is objective because it does not rely on a particular belief, value, or principle, but highlights the importance of cultural competence to facilitate living together peacefully in multicultural societies.

1.5 Determining Quality Standards and Indicators in Bioethics Education

In the fourth chapter, quality in bioethics education is defined as conformance to the goals. Furthermore, the goals of bioethics education are illuminated in the third chapter. Even though the determination of the goals and definition of quality provide significant indications of the insight into quality, these two chapters do not give any clues about measuring quality in bioethics education. However, clarifying the methodology of quality measurement is another fundamental part of this dissertation. In this context, the sixth chapter aims to outline a general framework to pinpoint quality standards and indicators in bioethics education in order to appraise the effectiveness of bioethics teaching. In the first section, the chapter elucidates some quality-related concepts and explains why an indicator-based approach is utilized to evaluate quality. The second section revisits the matter of determining the goals of bioethics education and defining quality to pave the way for the cohesion of the chapter. The third section analyzes and benefits from Donabedian's three approaches: structure, process, and outcome to form a model measuring quality bioethics education. The last section of the chapter clarifies the terms *standard* and *indicator* and formulates specific standards and indicators under structure, process, and outcome measures.

The study of quality brings several quality-related phrases including quality control, quality audit, quality assurance, quality measurement, quality assessment, quality management, and total quality management. Briefly investigating these phrases would be

beneficial in terms of conceptual clarification. Although each phrase addresses some exclusive meanings, all these terms are associated with ensuring, fulfilling, or maintaining quality. At that point, the phrase *quality management* is an umbrella term that covers many quality concepts and activities.[75] In other words, quality-related terms, such as quality control, quality assurance, and quality assessment, illustrate distinct facets of quality management. Additionally, it is crucial to note that in this dissertation, quality assessment, quality evaluation, and quality measurement are used as interchangeable.

In respect of the scope of this dissertation, a substantial matter is to compare the concept of total quality management (TQM) with the understanding of the model proposed by this dissertation, quality in all levels (QAL). TQM denotes an all-inclusive idea in quality management and regards quality as a continuous process that requires customer satisfaction as well as the commitment and cooperation of all individuals working for an organization.[76] Like TQM, QAL indicates a comprehensive approach by assessing quality in bioethics education in light of three levels: structure, process, and outcome and requests certain standards in all the levels simultaneously. Moreover, the people-oriented feature of TQM and QAL creates another similarity between these two approaches. Nevertheless, this situation does not make QAL a model or version of TQM because they contain distinct characteristics and assumptions. The analysis of the similarities and distinctions between the two models show that QAL is a unique approach aiming to measure quality in bioethics education while sharing some comparable aspects with TQM.

QAL employs an indicators-based approach to measure quality in bioethics education. Indicators-oriented methods are utilized by different fields including education

and healthcare as the reflection of evidence-based practices.[77] However, indicators-driven quality assessments are criticized by some due to certain arguments.[78] For instance, according to David Buck and his colleagues, indicators only measure inputs, not performances.[79] Pierre Lucier asserts that indicators do not carry the potential to clearly exhibits the picture in education because indicators only focus on quantitative points without shedding light on qualitative issues.[80] However, the indicators proposed by the present dissertation do not merely concentrate on quantitative measurements, but also qualitative benchmarks. Moreover, QAL does not only put emphasis on inputs and outputs, but also attributes equal importance to processes. In other words, QAL equally recognizes the value and significance of well-organized structures, well-implemented processes, and favorable outcomes in quality measurement. In this view, QAL considers bioethics education as an ongoing transformative process and specifies quality standards and indicators through quantitative and qualitative benchmarks to alleviate the disadvantages of indicators-oriented quality evaluations.

Another question needs to be expounded is about how to understand the notion of customer in bioethics education. In several industries, such as business, manufacturing, and marketing, the customer is the primary player paying for the product or service and influencing various aspects of the product or service through his/her/its perceptions, expectations, needs, and satisfaction.[81] Avedis Donabedian uses the term *consumers* instead of *customers* in healthcare. According to Donabedian, consumers are "coproducers of care," "vehicles of control," and "reformers of health care" in quality assurance.[82] In regard to education, it is necessary to underline that education has its own peculiarities; education is not a tangible product or service that can be directly bought or

sold; it is a dynamic and transformative process.[83] Paying for education does not change this reality. For this reason, we should shed light on the functions of education as teaching and learning and name its players as teachers and learners rather than customers, consumers, or clients. In this view, this dissertation prefers using the word *learner* to identify the person who benefits from bioethics education.

J. M. Juran counts input, process, and output as three components of the input-output diagram and implements this diagram to every step of quality planning. In the event of determining customers' needs, the list of customers refers to the input, the activities of discovering customers' needs denote the process, and the consequences of the activities address the output.[84] Avedis Donabedian adapts this model to healthcare as structure, process, and outcome measures in order to evaluate quality in healthcare.[85] Donabedian accepts the structure, process, and outcome approaches as equally crucial and complementary to gauge the quality of healthcare services systematically and comprehensively.[86] According to Donabedian, the structure, process, and outcome measures can separately and independently be employed. Nevertheless, because of the strengths and weaknesses of each approach, utilizing a combination of these measures would be more advantageous.[87]

The first component, the structure, encompasses three items: material resources, human resources, and organizational structure and administrative features.[88] The structure is established on two assumptions: the organization is capable to detect best staff qualifications, material features, and administrative practices; and appropriate material and human resources with a suitable organizational structure would bring quality in healthcare services.[89] The second component, the process, refers to the activities of an

organization to achieve its objectives. The process is a level between the structure and outcome where all the elements of the structure are taken into action to generate favorable results. The third component, the outcome, illustrates the consequences of all inputs, procedures, and activities.[90] Therefore, in the case of healthcare services, the outcome reveals "the integrated and cumulative effect of the entire range of health activities."[91]

QAL applies Donabedian's three approaches model to bioethics education to measure quality in this emerging field. In regard to QAL, the structure indicates the following inputs: curriculum, human resources, physical materials, physical facilities, and technological accommodations. The process in bioethics education points out the stage of transforming the inputs into certain outcomes. From this perspective, communication, teaching methods, teaching scope, teaching approach, evaluation, and observation are considered six dimensions of the process. The outcome signifies the goals of bioethics education: increasing ethical knowledge, improving ethical skills, developing ethical behavior, and promoting cultural competence. Additionally, because of the importance of satisfaction in quality assessment, QAL deems learner satisfaction as an expected outcome as well.

QAL constitutes specific standards and indicators under each component of the structure, process, and outcome measures in order to gauge the level of quality in each area. For instance, curriculum is a component of the structure, and QAL formulates at least one quality standard and indicator under curriculum to be able to create a measurable criterion in this particular area. The terms *standard* and *indicator* are elaborated differently in different sources.[92] However, in this dissertation, *standards*

represent certain general requirements or expectations regarding the attributes of the structure, process, and outcome to measure quality in these areas. *Indicators* denote the transformation of the standards into specific and measurable yardsticks. Indicators are more specific than standards and are derived from standards to codify measurable criteria. For example, “The teacher is qualified" is a structure-based standard under the component of human resources. This standard implies some requirements for the qualifications of the instructor. However, this standard is too general and needs to be specified to demonstrate which type of qualification is requested. In this context, it is the indicators, such as “the teacher has a relevant degree (at least a master’s degree) in bioethics,” giving details about the standard and composing measurable benchmarks. Therefore, according to QAL, the ultimate measurable points are the indicators.

The structure relies on the assumption that good inputs would produce good outcomes, and quality in these five components would directly impact quality in bioethics education. Curriculum is the first and essential components of the structure determining all pertinent issues, such as the content, teaching method, length, and place of the course, regarding the teaching of bioethics. The second component is human resources as teachers and learners. Even though human resources also encompasses administrative and other personnel, due to teachers’ and learners’ direct role in education, this component pays attention to teachers’ and learners’ acts and efforts. Physical materials, physical facilities, and technological accommodations are other fundamental components of the structure. Physical materials illustrate the syllabus, textbooks, and other teaching materials including classroom equipment, such as computers and projectors. Physical facilities refer to the area where educational activities are provided, such as the classroom

and library. Technological accommodations denote technological opportunities, chiefly the Internet-based facilities, such as e-library and e-classroom.

Process measures are the second dimension of QAL and most controversial components because of the subjectivity of the processes. QAL proposes a comprehensive and critical thinking-oriented teaching approach to motivate, inspire, and empower learners. Communication is the first component of the process requiring an effective communication between the teacher and learners to establish a positive learning environment.[93] The second component is teaching method showing teaching tools and responding to the question of "how to teach bioethics." Lectures with audio-visual aids, group discussions, real-life case analyses, short videos, role-playing, and student presentations are some recommended methods to teach bioethics.[94] The third component, teaching scope, pinpoints the content of teaching and sheds light on the question of "what to teach." For a solid ethical insight and analysis, QAL suggests teaching moral theories and ethical principles prior to studying contentious ethical subjects.

Teaching approach is the fourth component of the process and refers to the teacher's attitude toward learners while teaching bioethics. QAL advises the teacher to become a facilitator by empowering, encouraging, and guiding learners to express themselves as well as by supporting, respecting, and appreciating learners' thoughts, views, and concerns. Evaluation is another component of the process and necessitates a timely and fair grading and assessment. This point is important especially to fulfill learner satisfaction.[95] The last component of the process is observation and modification. According to QAL, a good teacher should also be a good observer to detect learners' reactions to existing teaching tools, content, and approaches. The teacher should combine

these observations with learners' feedback to alter the syllabus and make recommendations for changes in the curriculum in accordance with new conditions, needs, and expectations.[96]

The third dimension of QAL is outcome measures that consist of the four goals of bioethics education and learner satisfaction. Therefore, ethical knowledge, ethical skills, ethical behavior, cultural competence, and satisfaction are expected outcomes of QAL. The primary challenge concerning the outcome is to determine appropriate data collection methods and have sufficient observation time to evaluate changes in learners' knowledge, skills, and behaviors. In particular, in the case of a three-month bioethics course, it may be difficult to reach a conclusion regarding the influence of bioethics education on learners' behaviors. However, this difficulty should not prevent us from looking for the four goals of bioethics education and their outcomes.

1.6 Data Collection and Analysis Methods for Measuring the Indicators

In the sixth chapter, the standards and indicators are specified in accordance with the definition of quality and goals of bioethics education. However, the measurability of these indicators depends on appropriate and adequate data collection and analysis. As Avedis Donabedian underlines, data collection is "the life-blood of quality assessment."[97] In this context, the seventh chapter aims to elucidate research methods and data collection techniques to briefly portray the functioning of the quality indicators examined in the sixth chapter. The first section of the chapter investigates three research paradigms: quantitative, qualitative, and mixed research methods to provide some information regarding distinct data collection approaches. The second section succinctly examines four data collection techniques: document review, survey, interview, and observation to

illustrate how the indicators-related data can be obtained. The third section elaborates reliability and validity to emphasize the importance of quality of data collection and analysis. In the last section, the chapter sheds light on the Likert scale and the issue of ranking the standards and indicators to clarify the data measurement and analysis of QAL.

As Donna M. Mertens underscores, research is not just any kind of data collection activity, but an organized investigation to obtain and assess information to figure out, delineate, and anticipate phenomena.[98] Quantitative paradigm is one of the research methods collecting and analyzing information through numerical data and statistical correlations to achieve the abovementioned objective.[99] Quantitative research relies on the assumption that "a researcher can capture "reality" or "truth" within a certain level of probability" through numbers.[100] According to Burke Johnson and Larry Christensen quantitative research carries particular features: firstly, it is established on deductive reasoning that uses top-down logic; secondly, its focus is narrow because its aim is merely to test or confirm a specific hypothesis; thirdly, it is relatively free from the researcher's intervention due to utilizing numerical data and objective observations; fourthly, the data is analyzed through statistical correlations; fifthly, the findings are generalizable because of the number of samples, the random selection of participants, and the less possibility of human biases; and finally, the results are reported through certain mathematical techniques.[101] Revealing statistical significances with the researcher's judgment- and bias-free position is the main strength of the quantitative paradigm.[102] On the other hand, its limitation to exploring the multidimensional facets of social and behavioral sciences is a major weakness of this research method.

In contrast to the numerical data and statistical expressions-driven characteristics of quantitative research, qualitative paradigm employs a text-based and in-depth approach to comprehensively assess different aspects of a research area or subject. Because of its higher potential to analyze and understand complex social phenomena, qualitative research is chiefly considered a more appropriate method to investigate social and individual values, beliefs, and experiences.[103] Holly A. Taylor and her colleagues delineate the essential traits of qualitative paradigms as: the research focus is on the content; the research goal is to determine the truth through participants' individual values and experiences; the sources of data are mostly participants or respondents; and the domains of analysis indicate a flexible and dynamic research design.[104] Giving the researcher the opportunity to comprehensively examine individual, social, and cultural factors as well as the relationship and interaction among them is the primary asset of the qualitative paradigm. However, the researcher's higher role in the interpretation of the findings may also cause some subjective conclusions. Nevertheless, this weakness can be mitigated through the researcher's qualifications and experience by attributing sufficient attention to the issue of research validity and reliability.[105]

Quantitative and qualitative paradigms refer to the application of pure research methods. However, the disadvantages of these two paradigms lead to search for mixed research methods. In this view, the mixed research paradigm means to combine some attributes of quantitative and qualitative research methods in the same study.[106] In the event of a mixed research-based study, the study may overwhelmingly carry the features of quantitative or qualitative paradigm or equally benefit from both methods. The fundamental characteristic of a mixed research paradigm is to be able to use both

quantitative and qualitative methods in accordance with the requirements of the study design, data collection and analysis, and reporting techniques. Because of this possibility, QAL suggests implementing a mixed approach by utilizing the methods and techniques of both quantitative and qualitative research paradigms in data collection, data analysis, and reporting.

Document review is an essential data collection technique expressing the utilization of any written, printed, or recorded materials including reports, forms, notes, online-files, films, and videos for obtaining information in a study. Documents are regarded as "mute evidence" and can be used as the principal or supplementary source of information.[107] QAL has various indicators, such as "the curriculum exists" and "the syllabus defines expectations," that need to employ document review as the primary source of data collection. The second data collection technique is surveys that are self-reporting sources about surveyed individuals' personal thoughts, judgments, and experiences.[108] Different formats of surveys, such as mail, internet, telephone, and face-to-face, are available.[109] The validity of the questions, the size of the sample, and the attributes of the chosen samples are the most decisive issues in the success of this data collection technique. Many indicators proposed by QAL, especially the process measures-related ones, count on survey-based data collection.

Interview is another substantial technique having the ability to obtain solid information concerning individuals' thoughts, perceptions, and experiences in an interactive dialogue.[110] The survey technique is "a kind of conversation between a researcher and an informant."[111] Interviews are categorized as structured, semi-structured, and unstructured interviews. Structured interviews consist of fixed questions;

unstructured interviews contain open-ended questions; and semi-structured interviews are composed of predetermined questions while also providing the researcher and informant the opportunity to elaborate on any question or relevant issue.[112] Because of the nature of bioethics education, interview may be the most useful method to comprehend teachers' and learners' thoughts on the effectiveness of a bioethics course or program. Observation is the last data collection technique accentuated by QAL. Observation is chiefly a pure qualitative, but also a valuable technique used in social and behavioral sciences as a primary or secondary data collection method. QAL recommends the direct observation method, which considers the researcher an outsider, to monitor the research environment, the communication and interaction between teachers and learners, the performance and interest of teachers and learners, and the influence of bioethics education on learners, without interfering in the observed field.

Reliability is an essential criterion to ensure research quality. In general, reliability is described as attaining stable results under the application of the same research methods and measurement benchmarks. However, Dave S. Collingridge and Edwin E. Gantt claim that the concept of reliability should be examined separately in accordance with research paradigms.[113] According to this approach, in a qualitative paradigm-based study, reliability is not expected to generate the same results repeatedly, but produces consistent similarities.[114] In light of this approach, it is possible to state that reliability is a crucial standard in both research methods to control the accuracy of the research, but reliability in qualitative paradigm should be differentiated from reliability in quantitative paradigm due to their distinct characteristics. Furthermore, in comparison to quantitative research, in qualitative research, the researcher should be more meticulous

about choosing proper data collection instruments to achieve reliability. This vigilance should be taken into consideration while conducting a QAL-based study as well.

Validity is the second principle influencing the quality and acceptability of research and inquires whether the obtained data is the data that the researcher is looking for.[115] For example, if the researcher investigates the knowledge students acquired from a bioethics course, the collected data must have the ability to directly illustrate the level of the knowledge. Additionally, reliability is the precondition of validity, which means that prior to controlling validity, the reliability of the data must be affirmed.[116] However, even though reliability and validity possess disparate functions, both are complementary to each other to guarantee the credibility of research.

Reliability and validity of data play a prominent role in the overall reliability and validity of research. Nevertheless, collected data needs to be analyzed thoroughly and transformed into a measurable fashion. In this context, qualitative data can be converted into quantitative data to facilitate data analysis. QAL proposes benefiting from the Likert scale to turn textual statements into numerical data. The method is utilized commonly in social sciences, education, and healthcare, especially in surveys.[117] The Likert scale is a rating method limiting the number of responses and expressing each response with a number. For instance, a classic Likert scale sequences responses in a 5-scale category format in order of their favorability, such as never (1), seldom (2), sometimes (3), often (4), and always (5).[118] Although survey is a major data collection method in QAL, it does not only rely on this technique, but also document review, interview, and observation. For this reason, QAL considers implementing the Likert scale to the data obtained through all data collection techniques.

In addition to the Likert scale, QAL suggests the utilization of an analytic hierarchy process (AHP) to rank the quality standards and indicators in order of their importance. In a QAL-driven study, the researcher can determine the significance of each indicator, standard, sub-category, and main category in the structure, process, and outcome measures in accordance with the ad hoc situation, needs, or expectations of the educational institution, program, course. In this view, QAL advises a three-degree ranking as important, very important, and extremely important with the coefficient 1 for important, coefficient 2 for very important, and coefficient 3 for extremely important statements.

In conclusion, QAL is a model defining and measuring quality in bioethics education. Bioethics is an academic field which has been growing remarkably, with numerous institutions across the world. Even though an enormous amount of bioethics literature has come out in last five decades, it is difficult to encounter adequate studies elucidating quality in bioethics education or shedding light on quality measurement in this area. In this context, this dissertation has a significant potential to fill this gap by proposing QAL.

In QAL, the first and most important step is to determine the goals of bioethics education. Different studies address certain objectives to teach bioethics. However, QAL reflects a comprehensive formulation by utilizing Kohlberg's cognitive-developmental approach, Handelsman et al.'s ethical acculturation model, and the Delors Report's learning throughout life concept to specify the goals of bioethics education as: (1) increasing ethical knowledge; (2) improving ethical skills to strengthen ethical sensitivity, awareness, and judgment; (3) developing ethical behavior; and (4) promoting

cultural competence. Furthermore, the dissertation investigates the concept, understanding, and implementation of quality in some other academic discipline to define quality in bioethics education. QAL acknowledges bioethics education as an ongoing transformative process and considers quality as conformance to the goals. In other words, quality in teaching bioethics means fulfilling the abovementioned four objectives.

In respect of measuring quality, the dissertation suggests the application of indicators in accordance with Avedis Donabedian's structure, process, and outcome approach. In light of this perspective: curriculum, human resources, physical materials, physical facility, and technological accommodations are accepted as the components of the structure; communication, teaching method, teaching scope, teaching approach, evaluation, and observation and modification are regarded as the elements of the process; and ethical knowledge, ethical skills, ethical behaviors, cultural competence, and satisfaction are deemed as the segments of the outcome. In accordance with these main categories, several indicators are described as the measurement points. QAL recommends using both quantitative and qualitative research methods and data collection techniques to obtain pertinent information about the indicators. Moreover, the dissertation proposes employing the Likert scale with a variable coefficient to measure and analyze the gathered data in order to reach a conclusion about the overall quality of a bioethics program or course.

The dissertation does not merely attribute quality to outcomes, but also to the structure and processes. QAL assumes that without the effectiveness of the structure, process, and outcome simultaneously, any favorable outcome would be coincidental and temporary. For this reason, all the levels of bioethics education, the structure, process,

and outcome, should demonstrate adequate performance at the same time to achieve permanent and sustainable quality. This model, however, also encompasses some limitations. This is a normative model, and in the case of the application of this model, many unforeseen shortcomings may appear. First of all, the determination of standards and indicators requires a long-term cooperative effort according to an educational institution's specific objectives, needs, and conditions. Therefore, the proposed standards and indicators could always be modified in light of these requirements. Additionally, data collection methods and data analysis may also be reshaped in accordance with the researcher's approach as well as the ad hoc conditions of the research environment.

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2 Chapter - Learning from Experiences to Determine Quality in Ethics Education[1]

2.1 Introduction

Ethics is a common subject of almost all academic disciplines. However, the phrase *quality in ethics education* contains two major continuous debates. The first debate goes back to the time of Socrates in which it was discussed whether or not ethics could be taught. In regard to this point, a general consensus has been reached that ethics can be taught, even though there have been distinct arguments concerning the goals, models, and methods of ethics teaching.[1] The second discussion is about the quality of education. Until recently, traditional approaches assessed education by mostly quantitative measures and focused on its productivity. Nevertheless, especially through UNESCO's endeavors, a humanistic perspective, which proposes the integration of learning individual practical skills with developing social competence, has emerged.[2] This holistic approach is embodied in the Delors Report's four pillars: learn to know, learn to do, learn to live together, and learn to be.[3] Therefore, the aim and quality of education may be considered in accordance with the perspective of these pillars.

Many disciplines use the term quality to highlight certain features and perceptions of services, outputs, and outcomes. However, the widespread focus on quality does not avoid the complexity and ambiguity of this concept.[4] Quality is defined in numerous

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ways by different authors and scholars. Nevertheless, according to Reeves and Bednar, each definition encompasses some strengths as well as weaknesses in terms of "measurement and generalizability, managerial usefulness, and consumer relevance."[5] Furthermore, due to the presence of many different components and a comprehensive domain of quality, the authors do not consider an all-inclusive, successful universal definition possible. From this perspective, as Reeves and Bednar underscore, it may be difficult to produce a definition of quality to address and satisfy all elements, objectives, and expectations of all disciplines. Nonetheless, each academic field may outline a specific definition of quality in accordance with its unique characteristics. For instance, the Agency for Healthcare Research and Quality (AHRQ), an institution of the U.S. Department of Health and Human Services, describes quality in healthcare as "[d]oing the right thing (getting the health care services you need), [a]t the right time (when you need them), [i]n the right way (using the appropriate test or procedure) [t]o achieve the best possible results."[6] On the other hand, the World Health Organization (WHO) explains quality in a health system by denoting six dimensions: effective, efficient, accessible, acceptable/patient-centered, equitable, and safe healthcare.[7]

In this context, certain definitions, dimensions, and models may be borrowed from other academic areas to draw a general framework for quality in ethics education. However, exploring the existing situation of ethics education may provide a more concrete picture. Furthermore, without possessing adequate data and information regarding the current ethics education programs and without utilizing actual experiences, it might be difficult to thoroughly appraise and measure the quality of ethics education. For this reason, the purpose of this chapter is to review the literature on ethics education

to look at the existing ethics teaching programs in order to figure out whether it is possible to explore some indications of what quality in ethics education is.

2.2 Method

The study reviews the literature through concentrating on the ethics programs' teaching scope, teaching method, and classroom model in light of students' and educators' perception, the performance of the programs, and the effectiveness of the programs. The teaching scope refers to the content of the programs, teaching hours, and teaching period (where the course is placed). In other words, the phrase "teaching scope" indicates what, how long, and when ethics should be taught. The teaching method demonstrates the issue of how ethics should be taught, whether by traditional methods, such as one-way lectures, homework readings, and writing exams or through contemporary teaching styles, like case discussions, small-group debates, and oral presentation. The classroom model is about whether ethics education should be given as a separate ethics course or as a concept of integrated into some other courses. Additionally, the issue of whether applying a conventional face-to-face classroom system or having online distance learning and whether ethics courses should be required or elective are examined under the classroom model.

The methodology of this chapter is developed through the utilization of the focus subjects of the reviewed studies, to evaluate the perception of students and educators as well as the performance and effectiveness of the programs, in light of teaching scope, teaching method, and classroom model. Additionally, the relevance of perceptions, performance, and efficiency to the determination of quality and the examination of different processes in the identification and assessment of quality strongly persuaded the

author to use this methodology, and divide ethics teaching into three categories: teaching scope, teaching method, and classroom model.[8]

The relevant data was obtained by utilizing Duquesne University Gumberg Library's Discovery System-Quick Search that consists of about 20 databases including CINAHL, ERIC, PsycINFO, and Scopus®. The research was limited to the last 6 years from 2010 to 2015 inclusive. Data collection was carried out through reaching peer-reviewed, full-text articles with subject terms "ethics" or "ethics education" and titles containing the phrases of "ethics education," "ethics teaching," or "ethics learning." In accordance with the defined scope, 34 scholarly articles were found: 26 research articles, 4 review articles, and 4 theoretical articles. The research articles covered the studies from 11 distinct academic disciplines: Nursing (7), Medicine and Health Science (6), Psychology (3), Business (2), Education (2), Ethics (1), Science and Engineering (1), Social Work (1), Public Relations (1), Information Systems (1), and Accounting (1) and were from the following countries: the United States (12), Australia (2), Taiwan (1), Belgium (1), Egypt (1), South Korea (1), Ireland (1), New Zealand (1), and Switzerland (1). Furthermore, 3 research studies were international, and 2 others were about North America (the United States and Canada).

2.3 Review Findings

The diversity of the studies in terms of their scope, methodology, academic discipline, and research area allows for taking a broad picture of ethics education. However, it also obstructs the ability to make detailed inferences. Therefore, instead of heeding every conclusion of each study, the most striking parts were consolidated to form worthwhile results. In this context, the highlighted points of each study were

systematically listed, and common matters were taken into account under the following subsections.

2.3.1 Teaching Scope

Nineteen studies point out certain issues about constituting an ethics curriculum, the basic features of content, and teaching hours. The most emphasized matter is the need for creating a convenient and applicable ethics curriculum. Six studies underscore the importance and necessity of generating a curriculum encompassing and demonstrating all the relevant subjects that are supposed to be taught.[9] For example, the study examining obstetrics-gynecology residency programs indicates “a lack of structured curricula” and suggests a well-designed, acceptable, and a universal curriculum “to achieve competency in the key dimensions of professionalism and interpersonal and communication skills.”[10] Similarly, Marwa M. Fawzi proposes forming an applicable “model curriculum” that helps medical students gain essential ethical knowledge and skills.[11] Furthermore, Anne Hudon et al., who reviewed the curricula of 27 Canadian occupational therapy and physiotherapy programs, stress the significance of developing an ethics curriculum to enhance the students' ethical decision-making abilities.[12]

The content of the ethics programs is another point frequently emphasized. Contrary to the general assumption that the teaching of ethical theories is not supported, 6 studies, four of which are about nursing programs, underpin the learning of ethical theories.[13] These studies show an explicit demand for teaching theories with ethical principles and codes. The international research study in public relations, carried out by Austina and Toth, demonstrates that educators back “a fine balance between theory and application.[14] Additionally, Cannaerts, Gastmans, and de Casterle denote the integration

of ethical theories and practices for effective outcomes.[15] Fleischmann, Robbins, and Wallace also emphasize the teaching of ethical theories, but they suggest teaching of theories for a better understanding of cultural differences.[16] Thus, besides improving ethics-related knowledge, skills, and abilities, strengthening cultural competency and sensitivity is another goal of ethics education. In this sense, ethics curricula should have a cross-cultural approach to satisfy cultural and social differences.[17]

The teaching of ethical principles and professional codes are also welcomed by both educators and students.[18] However, it is an intriguing finding that the studies in nursing and psychology accentuate the learning of ethical principles and codes more than the other academic fields. This situation might be due to that in comparison with some other academic disciplines ethical principles and professional ethics codes have been much more grounded in medicine and health sciences. In regard to ethical principles, Beauchamp and Childress' four principles are more popular.[19] However, according to some educators, the teaching of these principles contains both advantages and disadvantages. On the one hand, learning the principles may allow students to have some tools to apply to ethical issues. On the other hand, it may preclude students from making comprehensive ethical judgments.[20]

The studies do not reveal a lucid picture concerning ethics program hours to draw a conclusion. Merely three articles touch on the hours of ethics teaching, and even these three studies show a wide range of hours between 4 hours and 32 hours.[21] Nevertheless, the studies exhibit an increase in as well as a demand for ethics education. For example, the international research study about ethics education in business schools indicates that

ethics-related courses doubled in 5 years from 2005 to 2009.[22] Some other studies also explore that educators especially request more ethics education.[23]

2.3.2 Teaching Method

The teaching method of ethics is as important as teaching scope for the effectiveness of education. Teaching scope demands a well-designed curriculum, whereas the teaching method refers to the ways of actualizing the curriculum. A well-structured curriculum may not produce successful consequences without applying appropriate methods. In this context, the studies illustrate largely the implementation or recommendation of lectures (7 studies), case-based teaching (7 studies), group discussions (5 studies), and assigned readings (3). In other words, though educators' and students' approaches toward teaching methods differ slightly among distinct studies, lecture type, case-based teaching, and group discussions are most applied or demanded methods.[24]

The study reflecting nursing students' perspectives in Belgium shows that the students appreciate case-based learning with lectures, while quite more than half of the students believe group discussions have little or no impact on "their ethical development."[25] However, another study done in Belgium, which represents nursing students' and educators' viewpoints concerning teaching methods, indicates that besides case studies, the students value group discussions as well.[26] Similarly, the study in laboratory medicine training programs demonstrates that lecture-style teaching is popular across the world, whereas the study carried out by Carolyn A. Laabs in the United States disapproves of lectures.[27] However, Rodríguez et al. state that "lectures may be the most

efficient and effective strategy for accomplishing … the acculturation of ethical professionals."[28]

The phrases "case studies," "case-based learning," "problem-based learning," "case method," "practical teaching method" are used by different studies, but all of them describe a teaching method utilizing tangible cases to clarify the understanding of learners in ethical confrontations.[29] This method is regarded as rather useful by students, educators, and researchers.[30] Nonetheless, according to Johnson and his colleagues, the effectiveness of case-based learning depends on the quality of used cases.[31] Furthermore, another interesting finding mentioned by two distinct studies is that even though case-based learning is considered effective and beneficial, in Taiwan and Japan lecture-style teaching is implemented because students from both countries are not used to or do not feel comfortable enough for an interactive learning system.[32] This situation might be explained by cultural differences and their influence on teaching models in these countries.

Moreover, it is important to note that the aforementioned methods do not require substituting one of them for another. The application of distinct methods in the same curriculum is possible and plausible through the combination or integration of more than one method. For instance, the research done by Carolyn A. Laabs considers the implementation of case studies, group discussions, and readings essential.[33] For this reason, lectures, case studies, discussion groups, presentations, film reviews, and readings or some combinations of them can be used in the same curriculum in accordance with their expected efficacy.

2.3.3 Classroom Model

As mentioned above, there is an obvious request for increasing numbers of ethics-related courses and course hours. However, there is not a consensus on the classroom model of ethics education. Some educators and students are proponents of having separate ethics courses, whereas some others support the integration of ethics into the whole curriculum.[34] In other words, though educators and students argue different views on whether ethics education should be given as a separate course or integrated course, they agree on providing more ethics education. On the other hand, Rasche, Gilbert, and Schedel claim that "an increase in the absolute number of ethics-related courses might be misleading, as effective change needs to address the underlying structure of [a] curriculum (e.g., in terms of addressed disciplines) and not only the number of courses."[35] Therefore, ethics education does not only need quantitative increases, but also requires qualitative improvements.

The issue of whether having face-to-face ethics courses or online courses is another subject of the classroom model. Instead of asserting an alternative to a classical classroom system, some studies recommend online sources as supplementary to reinforce existing ethics education. David E. Bruns et al. point out "a desire for online resources to aid in ethics training in laboratory medicine."[36] Marwa M. Fawzi recommends "an online medical ethics forum" in order to both update developments in medical ethics and create a virtual area where physicians can talk about new ethical challenges.[37] Additionally, Godbold and Lees implement a web-based application called *the Values Exchange* employed to help users in ethical decision-making procedures, and both clinicians and students evaluated this web-based technology as beneficial to alleviate the gap between

ethical theories and practices.[38] Similarly, Larysa Nadolny and her colleagues designed a project named *the SciEthics Interactive* providing virtual stimulations and gauged its results. According to their study, the virtual stimulations enhanced students' knowledge of ethical issues.[39]

2.3.4 Perception

The perception of educators and students is crucial in ethics education. If an educator trusts a content and teaching method of a curriculum, she/he would be more productive. On the other hand, without students' perception of the usefulness of the teaching style and content, it would be difficult to contribute to students as much as expected. Students' active participation in courses is essential in terms of the effectiveness of teaching ethics.[40] Cubie L . L. Lau states that "if students are willing to learn and perceive ethics education as useful, learning outcomes are improved."[41] Furthermore, Heather E. Canary et al. stress the necessity of students' confidence in ethical debates.[42] Thus, to establish a better framework of ethics educations, educators' and students' expectations, feelings, and perceptions should also be taken into account.

The studies explicitly indicate two points. The first one is that educators and students believe that ethics teaching positively influence students' ethical awareness, knowledge, and reasoning, but more ethics education should be provided to enhance students' ethical understanding.[43] The study conducted by Cannaerts, Gastmans, and de Casterle explores that both students and educators accept that ethics education create substantial consequences, but the current devoted time to ethics courses is not adequate to study all ethical matters deeply, so the existing situation leads to perfunctory teaching.[44] Similarly, according to John Byrne and his colleagues, the directors of obstetrics and

gynecology residency programs highly credit ethics education, but the existing curriculum with the designated time precluded achieving the desired results.[45] The second point is that despite not rejecting lectures and teaching of ethical theories, students tend to learn tangible ethical norms, codes, and principles to be able to apply them to their professional practices.[46] For these reasons, problem or case-based learning, principles and codes, and group discussions are valued by students. However, some students and educators also place confidence in lectures and the teaching of theories.[47] In this sense, certain studies suggest a combination of theories and practical information and applications.[48]

2.3.5 Performance

The performance of the current programs illustrates how well the programs work. Therefore, without implementing a program, it is not possible to evaluate its performance. As the studies reveal that even some medical and nursing programs still do not offer formal and separate ethics courses, or the existing ethics teaching is unstructured in these programs.[49] Of course, ethics is not the only issue in medicine and health sciences; in light of contemporary moral values, ethics is operative in all academic disciplines. Nonetheless, in comparison with several other fields, the confrontation of health professionals with ethical challenges is highly more likely due to the number of people and matters they encounter. However, an international survey in laboratory medicine training programs demonstrates that the majority of the programs do not have formal ethics teaching.[50] Likewise, the study done by Chiou-Fen Lin et al. in Taiwan proves that many nursing schools cannot provide a separate ethics course because of the lack of ethics instructors.[51]

Even though all the present studies do not specify the details of programs regarding how well they function, these findings indicate that certain ethics programs perform well. Nonetheless, there are also many impediments diminishing the performance of ethics teaching. Limited time is one of these obstacles. The survey of 136 ethics educators from American Psychological Association accredited programs in the United States and Canada underlines the inadequacy of length of ethics courses which avoids studying of all substantial ethical topics.[52] Similar problems are expressed for the nursing programs in Taiwan as well as in Belgium.[53] Additionally, the shortage of educators and the lack of educators' experience in ethics education are also barriers affecting the performance of ethics teaching. An interesting point is that instructor-based difficulties are not merely the challenges of countries where ethics education has been recently flourishing, but also these problems can be seen in the United States where ethics has been a major academic field since the beginning of the 1960s.[54] The study examining ethics education for the doctor of nursing practice exhibits "that many nurse faculty do not have formal education in ethics, leading to unintentional misinformation when such faculty are responsible for ethics education."[55] Furthermore, limited resources, unstructured curricula, and crowded curricula are some other handicaps of ethics education highlighted by the studies.[56]

2.3.6 Effectiveness

Effectiveness refers to the results of an implemented ethics program. The distinction between performance and effectiveness might be confusing. However, in this chapter, the term performance points out the application of a program regardless of its consequences, whereas effectiveness looks into the outcomes of a program. In other

words, performance focuses on whether a program is applied successfully, while effectiveness concentrates on whether the results of an implemented program are effective.

In this context, the majority of the studies (18 studies) underscore the effectiveness or ineffectiveness of certain parts of the ethics programs. Fifteen studies find that certain ethics teaching methods create positive consequences. In other words, an overwhelming number of studies accentuate that ethics education significantly increase students' ethical awareness, reasoning, sensitivity, judgment, knowledge, perspective, and personal values.[57] However, there is not an exact consensus on which teaching style is more effective. For instance, the survey of APA accredited programs considers lectures the more effective method, whereas in obstetrics and gynecology residency programs regards lectures as the least effective way.[58] Nonetheless, it can be stated that in regard to effectiveness, case-based learning is mostly preferred to lectures.[59]

Contrary to the majority of positive perceptions, the research study reflecting third-year baccalaureate nursing students' perception of ethics education in Belgium shows that "the overall effectiveness of ethics courses is limited."[60] Nevertheless, the experimental design including two samples of business undergraduate students and carried out by Cubie L. L. Lau proves opposite findings that ethics education significantly impact the students' overall ethical awareness, orientation, reasoning, and sensitivity. However, the same study indicates that ethics education does not change the students' "view of the world."[61] Moreover, the study conducted by Mary Jo Loughran et al. determines that the applied ethical activities did not increase the students' self-confidence.[62] Additionally, the comparative literature review done by Liu, Yao, and Hu

demonstrates that ethics education in accounting is not as effective as it is in medicine and law.[63] As a result, even though the majority of the studies accept the effectiveness of ethics education, few studies assert either the overall or partial ineffectiveness of ethics teaching.

2.4 Discussions

Cathy L Rozmus and her colleagues state that "teaching ethics is not a hopeless task" and suggest grabbing students' attention by making ethical issues interesting.[64] They also recommend supporting students to express themselves and to become open-minded about differences. Therefore, for better consequences of ethics education, certain suggestions can be implemented. Nonetheless, the first step in ethics teaching should be to clarify the aim of ethics education: whether the aim is to increase ethical awareness, judgment, and reasoning, to enhance professionals' knowledge to be able to respond to daily ethical confrontations, to foster cultural competence and sensitivity, to change or shape personal attitudes, behaviors, and view of the world, to provide students certain knowledge allowing them to find a job, or something else. Giacalone and Promislo explain the aim of ethics education as expanding students' horizon that requires empowering students with a vision "to live a virtuous life and build a virtuous world."[65] Therefore, Giacalone and Promislo ascribe a virtue-based task to ethics education. However, Kevin Breaux et al. determine that ethics learning does not have a significant function in obtaining positions in accounting, and they ask "if recruiters do not value ethics coursework … should colleges and universities offer these courses?"[66] Thus, contrary to the former approach, the latter idea circumscribes ethics education to only its tangible consequences.

John Tillson underlines that ethics, religions, and certain non-religious systems try to "answer the Socratic question 'how should one live?"[67] In this context, he emphasizes the necessity for teaching religious as well as non-religious perspectives. However, he thinks it is not feasible to teach non-religious ideas besides a religious educational structure and concludes with recommending ethics education for teaching different values, thoughts, and approaches.[68] Furthermore, Bouchard and Morris examine the Quebec Education Program's ethics and religious culture course and attribute the achievement of moral education programs to their attention to "the empirical, existential and social world of learners."[69] Therefore, all the aforementioned positions address distinct aims and aspects of ethics education: instilling in students certain virtues and creating a virtuous world, obtaining specific ethical knowledge, skills, and abilities to find a job, teaching both religious and non-religious perspectives, and paying attention to learners' social world. In this sense, without identifying the purpose of ethics education, directly describing particular methods and models might be irrational.

Besides determining the aims of ethics education, deciding what to teach and how to teach are crucial questions in ethics education. Jensen and Greenfield recommend not limiting ethics education to teaching specific ethical theories, codes, and principles, but improving "students' ability to develop habits of mind" in order to increase the understanding of what, how, and why they act in case of encountering ethical issues.[70] Moreover, it could be meaningful to underscore that ethics education should not merely focus on the development of individuals' ethical knowledge, skills, and abilities. Producing a global perspective recognizing and accepting cultural and social diversity as

well as encouraging students to realize their place and role in society should also be the matters and aspects in which ethics education is engaged.[71]

As the studies clearly exhibit, though facing several shortcomings and impediments, ethics education creates positive and promising outcomes. To improve the current situation, more ethics education with well-established curricula is needed. However, this does not only mean to increase the number of ethics courses and hours, but also it necessitates structural changes.[72] Striking a balance between theories and practical cases, providing lectures with students' active participation, supporting group discussions and students' self-expression, and backing content and teaching methods with technological opportunities and sources would contribute to restructuring ethics education.[73] Moreover, it should be taken into consideration that educators play a prominent role in the effectiveness of ethics education. For this reason, the education of educators must come first because the lack of ethics educators and educators' experience in ethics are major obstacles to provide ethics education in an effective manner.[74]

On the other hand, in terms of the issue of quality, the reviewed studies do not provide a lucid picture to outline a general framework. In light of the findings of the studies, it may be emphasized that the existing ethics teaching programs are far from making a concrete quality assessment and measurement, due to certain reasons. First, quality indicates the acceptability of performance.[75] Without performing ethics education, it would not be possible to gauge the quality of it. In this sense, ethics education has not settled in all academic disciplines adequately. For instance, although healthcare is a leading field in ethics, and the application of moral principles to medicine goes back to the Hippocratic Oath, some medical and nursing schools across the world have not still

had a formal, satisfactory ethics education. In case of the absence or inadequacy of ethics teaching, quality-based discussions would not be grounded sufficiently. Therefore, under current circumstances, the reviewed studies naturally concentrate on the implementation of ethics programs rather than their quality. Second, without determining the purpose of ethics teaching, it may not be feasible and plausible to talk over quality. Goals are decisive factors in quality measurement that need to be decided prior to the application of ethics programs. Nevertheless, the studies do not demonstrate limpid findings to denote specific common goals for ethics education. Third, ethics education is supposed to improve recipients' (students) ethical knowledge, skills, and behaviors. In the event of quality measurement, these three areas should be appraised to determine whether expected consequences are produced. For this reason, quality indicators and assessment standards should be set. However, the reviewed studies do not supply sufficient clues on how to form the indicators and standards.

Yet, it is believed that a general framework for quality in ethics education could be established by determining the goals of education, indicators of quality, and standards of measurement. The experiments of other academic disciplines may be utilized to shape core goals, indicators, and standards. However, the unique characteristics of ethics education should also be taken into consideration during this evaluation. Ethics is grounded in moral values, religious beliefs, cultural practices, and political perspectives. The outputs of ethics teaching are not as tangible, objective, and measurable as the outputs of business, marketing, or healthcare. Therefore, creating universal goals and standards as well as gauging the impact of ethics education on recipients might be difficult. Nonetheless, a teaching scope, teaching method, and classroom model-based

classification as well as a perception, performance, and effectiveness-focused assessment may reify this abstract area to generate quality-related indicators and standards.

2.5 Conclusion

The findings demonstrate that through the necessity and usefulness of ethics education are confirmed by all the parties, the perception of the students, educators, and authors on the quality of the current programs indicate that there is still a great deal of room for improvement. Additionally, although the students, educators, and authors largely believe that ethics education is effective in enhancing ethical awareness, knowledge, and reasoning, certain shortcomings in the determination of teaching scope, teaching methods, and classroom models affect the results of ethics teaching and learning. The lack of dedicated time for ethics courses, the lack of educators' skills and experience in ethics, and the lack of formal ethics education are negative factors that influence the performance of the programs. The studies show that case-based teaching is the most desirable model. However, for a comprehensive understanding of ethics, an appropriate integration of theories and cases are also supported. Moreover, ethical principles and code-oriented teaching is welcomed by students. Even though there is an obvious need for formal ethics education, there is no concurrence on the issue of whether ethics education should be given as a stand-alone course or integrated into relevant courses.

The reviewed studies do not provide sufficient indications to explain what quality in ethics education is and which standards and indicators it has. However, the studies gave an opportunity to see students' and educators' perceptions and expectations about ethics education as well as the performance, benefits, shortages, and shortcomings of the

current ethics programs which may help to draw a general framework as a starting point for examining quality in ethics education.

In light of an overall assessment of the studies, the following three suggestions are proposed. First, a sufficient number of formal ethics courses should be provided by educators having adequate education and experience in ethics. Second, for improving the performance and effectiveness of programs, well-structured curricula, theory- and practice-integrated courses, and a continuing education are recommended. Third, education should give students an ethical perspective that transcends teaching certain ethical principles and codes. Ethics education should also strengthen cultural sensitivity, individual tolerance, and dialogue towards persons, groups, and societies with socially, economically, and culturally different characteristics.

This study contains certain limitations. This literature review consists of 34 scholarly articles: 26 research articles, 4 review articles, and 4 theoretical articles. The research articles cover the studies from 11 distinct academic disciplines (3 international studies and the studies from 10 different countries). Therefore, the sole common point of the studies is ethics education. This is an advantage to draw a complete picture of ethics teaching. Nevertheless, the diversity in academic disciplines, research methodologies, and research approaches avoids digging into each matter in detail. Furthermore, even though different studies' show similar findings and results are assessed and integrated, the distinction among the research circumstances and focuses of each study may weaken some conclusions of this study.

Despite these limitations, it is believed that this study contributes to learning from experiences in order to determine the existing situation of ethics education and generate a

framework for an effective ethics education. However, a global perspective to ethics education is still in a nascent stage. Therefore, more studies are recommended to elucidate quality in ethics education.

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3 Chapter - A Short History of the Emergence of Bioethics and Bioethics Education[2]

3.1 Introduction

In the preface of *A Short History of Medical Ethics*, Albert R. Jonsen introduces bioethics as the "newer version" of medical ethics.[1] Jonsen does not provide details concerning the characteristics of old and new versions, but he describes the change as a progression in medical ethics, rather than a replacement of traditional duties with new duties.[2] Beauchamp and Childress specify this alteration by the deficiency of the Hippocratic tradition in contemporary issues, such as privacy, informed consent, and research with human subjects.[3] However, bioethics-emerging factors did not appear "with a Big Bang."[4] Nazi's atrocious medical experiments and some other research with human subjects, like the Tuskegee Syphilis experiment, political and judicial engagement in healthcare ethics, human rights developments, and liberal policies brought about a new approach in health-associated areas to place adequate attention on individual liberty as well as justice in the allocation of benefits and burdens. Furthermore, two American institutions' (the Hastings Center and Kennedy Institute) efforts to promote and endorse bioethics, United Nations Educational, Scientific, and Cultural Organization's (UNESCO) commitment to establish universally acceptable bioethical principles, and the

[2] The section entitled "Bioethics Education" is partly retrieved from "Drawing on Other Disciplines to Define Quality in Bioethics Education" by Ercan Avci, *Quality in Higher Education* 23, no. 3 (2017) 201-212. The copyright agreement gives the author the right to use his article in his dissertation.

government's involvement in bioethics, in the United States, by forming consecutive commissions, have facilitated the spread of the new human rights-based medical ethics. From this perspective, the aim of this chapter is to briefly examine the history of bioethics and the progress in bioethics education to clarify the evolution of medical ethics and its teaching. In this context, this chapter begins with assessing the pre-bioethics period by succinctly looking at the Hippocratic Oath, Galen ethics, and Thomas Percival's approach. The chapter continues with debating the discovery of the term *bioethics* and its development as a new multidisciplinary field. Prior to concluding, the history of bioethics education will concisely be evaluated, and the contribution of three specific works to bioethics teaching will be highlighted.

3.2 Pre-Bioethics Era

Ethics is an umbrella term containing distinct moral classifications. However, in general, it is possible to describe ethics as a study analyzing the moral acceptability of human actions and applying the formulated moral norms to actual cases in different fields including medicine.[5] Ethics requires the consideration of moral rules and the practice of this morality in daily problems. Medical ethics is the application of this philosophical approach to medical activities, decisions, and interventions. Even though there are some mysteries about the Hippocratic Oath's origin, its prevalence and acceptance in its own time, and its influence in the subsequent centuries, the Hippocratic Oath proves that medicine has recognized and implemented certain moral norms since the time of Hippocrates. This situation makes the history of medical ethics as old as the history of medicine, since the time of Hippocrates is acknowledged as the beginning of medicine.[6] However, it is obvious that from the time of Hippocrates to the present time, the ethics in

medicine or healthcare has significantly changed. In this view, prior to elucidating the appearance of bioethics, concisely looking at medical ethics in the pre-bioethics period would be beneficial to comprehend the evolution of ethics in healthcare.

3.2.1 The Hippocratic Oath

In some countries like Turkey, whenever physicians breach moral rules or patient rights, they are condemned not only due to their actions, but also because of violating the Hippocratic Oath. Similarly, physicians sometimes defend themselves and refuse blame by underscoring how loyal they are to the Hippocratic Oath they took at the beginning of their professional life. This anecdote demonstrates that the Hippocratic Oath is the symbol of moral conduct both for lay people and physicians. Not merely medical students in Turkey, but also in other countries, many medical schools have used either the classical or a modified version of the Oath as the ritual of commencements for many years.[7] The overwhelming majority of the oaths taken during graduation ceremonies indicate moral values far from the moral perspective reflected by the original Hippocratic Oath.[8] Nonetheless, all these oaths are still called 'Hippocratic Oath.' Furthermore, the general perception regarding the Oath in medical ethics and literature indicates that the Hippocratic Oath denotes something more than a custom of graduation ceremonies; mostly "the foundation of medical ethics for physicians."[9]

The Hippocratic Oath is a document addressing certain moral stances in practicing medicine. The Oath's estimated date of birth is about 400 BCE. However, the only fact we know about the Oath is that it is an ancient Greek script. As Steven H. Miles expounds, the author or authors of the Oath is/are unknown; it is unclear that whether the Oath had any significance and impact during the period it was formed; and there is no

hint whether it was the only oath composed at that date.[10] Amid these questions, Miles accentuates the possibility that there might have been several similar oaths, but only the Hippocratic Oath could reach us.[11] Miles' speculation seems plausible because there were different schools in ancient Greece teaching "different medical and philosophical beliefs."[12] Therefore, the Oath may have merely been illustrating the religious or philosophical position of one of these schools or a group in ancient Greece. Ludwing Edelstein claims that the Oath does not mirror the ethics of all ancient Greek physicians, but "a small segment of Greek opinion."[13] Edelstein identifies this group as the Pythagoreans. According to Edelstein, it was only the Pythagoreans supporting and representing the moral values depicted by the Hippocratic Oath because contrary to the Oath's reflection, ancient Greek physicians were performing surgery, assisting patients who requested suicide, and providing abortive drugs.[14] Edelstein's opinion concerning the origin of the Oath and its recognition in its own time is the ground for many ethicists to regard the Oath as the Pythagoreans' religious reading shaping their approach to medical practices.[15] Additionally, according to Robert M. Veatch, it is not only Edelstein addressing the connection between the Oath and the Pythagoreans, but some other studies also have reached the same conclusion for three centuries.[16] However, Albert R. Jonsen emphasizes the criticism about Edelstein's interpretation that explaining the morality in ancient medicine merely by the Pythagorean philosophy is an inadequate approach to elaborate the complicated structure of ancient medicine.[17]

Another important discussion around the Hippocratic Oath is about its survival; if it was not commonly accepted and applied in ancient Greece, how could it reach to the present day and how was it rediscovered? Edelstein calls the first part of the Oath

covenant and the second part *ethical code* and asserts that both parts are consistent with the Pythagorean philosophy manifesting a religious mindset, but inconsistent with medical practices at the time of Hippocrates. In Edelstein's view, the Oath did not find a widespread ground until the beginning of the Middle Ages, but the similarity between Pythagoreanism and Christianity on certain concepts and practices, such as purity, holiness, and abortion, brought about a rapid rise in the popularity of the Oath in the Medieval Period.[18] Robert M. Veatch specifies the influence of the Oath on the Medieval Period by citing from others like Carlos Galvao-Sobrinho, Antonia Garzya, and Jacques Jouanna and comes to a judgment that in the early Middle Ages, the Oath had limited leverage on Christian medical ethics.[19] However, the interaction between these two distinct religious traditions increased in the later Middle Ages, and Veatch describes the growing effect of the Oath on Christian medicine as "assimilation of Christian and classical Greek culture" by the pagan Hippocratic Oath.[20] In terms of the relationship between the Oath and other religions, Islamic sources and studies show that the Oath played a significant role in medieval Islamic medical ethics, and the slightly modified version of the Oath was adapted in Islamic medical practice.[21]

Along with the above-mentioned considerations, inquiring whether this pagan religion-oriented document has any merit is also an essential question. Edelstein chiefly highlights the Pythagoreanistic characteristic of the Oath and disdains the value of the Oath by concluding as "the Hippocratic Oath is a Pythagorean manifesto and not the expression of an absolute standard of medical conduct."[22] Veatch reveals a similar point of view on the religious feature of the Oath, but limits his criticism to inapplicability of the Oath to modern medical ethics. Veatch says "my aim is not to suggest it was

inappropriate for the group practicing Hippocratic medicine in ancient Greece. Rather, I am saying the Oath is seriously deficient for dealing with the medical morality of the present day."[23] Veatch details the reasons why he believes the Oath cannot satisfy contemporary medical ethics, but it is possible to summarize his arguments under the paternalistic and absolutistic traits of the Oath which merely concentrate on the physician's personal judgment and benevolence with the moral certainty of its rules.[24] However, Jonsen is a critic of Edelstein's stance on the merit of the Oath. According to Jonsen, oath-taking was common in the ancient Greek culture, and the Hippocratic Oath is a part of this culture and reflects a pure deontological approach.[25] He delineates the Hippocratic ethics as "an ample exposition of decorum that can be seen either as mere etiquette or as an ethics of virtue and character."[26]

The Hippocratic Oath promises eight commitments; some of them require positive obligations as to do something, and some other contain negative obligations as to avoid doing something as follows:

- benefiting patients: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment;"

- avoiding harm and injustice: "I will keep them from harm and injustice."

- not providing lethal drugs and not promoting suicide: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."

- not providing abortive remedies: "I will not give to a woman an abortive remedy."

- promising purity and holiness: “In purity and holiness I will guard my life and my art.”

- not performing surgery: “I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such mean as are engaged in this work.”

- refraining sexual relationship with patients: “whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.”

- promising confidentiality: “What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.”[27]

Acknowledging all these obligations classified into eight categories as having no value in medical ethics would be a very harsh argument. Of course, it is probable to oppose these obligations either completely or partially in the case of comparing them with today’s medical ethics, as Veatch does. Nevertheless, totally rejecting the morality of this document, which was composed approximately 2500 years ago, may address a very optimistic view about the history of human beings. If physicians in even 1930s and 1940s were loyal to this religious, paternalistic, and deontological Oath or any modified form of the Oath, many atrocious incidents, such as Nazi physicians’ experiments and Tuskegee Syphilis Research, would not have occurred. Any interpretation of purity, holiness, justice, not harming, and producing benefits should have prevented the physicians from engaging in such brutalities. As a result, the Oath could be criticized due

to its religious, hard paternalistic, and deontological characteristics, but it does not prove that the Oath has no ground in the history of medical ethics.

3.2.2 Galen and Thomas Percival Period

In the historical development of medical ethics, Galen a physician in the Roman Empire is the most prominent character who reinterpreted the Hippocratic tradition by focusing on "a decorum ethics, stressing attitudes and virtues rather than rules and duties."[28] It is important to note that the term Hippocratic tradition does not indicate the Hippocratic Oath, but the medical practice of Cos an island in the Aegean Sea in ancient Greece.[29] The primary aim of Galen is to describe how it is possible to practice medicine like a physician of the time of Hippocrates and become "true followers of Hippocrates" which demands to acquire certain virtues.[30] From Galen's perspective, a physician should not be ambitious for money and pleasure because all evils stem from the appetite for financial gains and pleasure; temperance, honesty, and learning logical methods are essential virtues each physician must possess. According to Galen, all these necessitate learning logical, physical, and ethical parts of philosophy. In other words, "all true doctors must also be philosophers … in order to employ their art in the right way."[31]

Galen directly points out Hippocrates during defining ideal characteristics of physicians. However, it is not clear whether his description covers physicians the Hippocratic Oath portrays. Therefore, asserting any connection between the Hippocratic Oath and Galen's ethics may be difficult. Nevertheless, it is obvious that these two approaches reveal different moral grounds. The Hippocratic Oath demonstrates a deontological perspective by imposing specific rules without recognizing any exception or excuse, whereas Galen's position is established on a virtue-oriented character

description; a physician with certain virtues would perform his art in an appropriate manner like Hippocrates. For this reason, the former shows a deontological morality, while the latter illustrates classical traits of virtue ethics.

Post-Galen time was a silent period for medicine and medical ethics for about five centuries.[32] Moreover, Christian institutions' fluctuating engagement in medicine did not generate a significant transformation in the western medical ethics until Thomas Aquinas' natural law theory which indicates a reinterpretation of Aristotelian philosophy and relies on the belief that as a creation of God, through reason and experience, human beings can decide what is morally right and wrong.[33] On the other hand, some people draw a deduction that the Hippocratic Oath survived as a result of the religious and deontological common grounds between the Hippocratic Oath and Christianity. However, Veatch disputes such an argument by claiming that "there is virtually no evidence that early Christian writers were aware of the Hippocratic Oath … until about tenth century, when many Greek writings including the Hippocratic writings were recovered from Arabic sources."[34] From the ninth century to the end of Middle Ages, Muslim Scholars such as Razi (865-925), Ali ibn Abbas Ahvazi (Haly Abbas, 930-994), and Ibn Sina (Avicenna, 981-1037) played a more prominent role in medical ethics.[35]

John Gregory (1724-1773) and Thomas Percival (1740-1804) are two leading British physicians who shaped medical ethics in the modern era by transforming the general aspect of medical ethical into medical professionalism.[36] Laurence B. McCullough summarizes the major features of Gregory's and Percival's ethics through underscoring three fundamental characteristics of physicians: being competent by acquiring reliable medical knowledge and clinical skills; prioritizing their patients'

interest over their own interest and utilizing their knowledge and skills to benefit their patient; and acknowledging that "[m]edicine does not belong to physicians alone but it is a corporate and social entity that exists primarily for the benefit of patients and science."[37] In light of this approach, certain similarities can be seen between Gregory's and Percival's professional ethics and Galen's ethics as well as the Hippocratic Oath. Galen explains certain virtues to identify an ideal physician and rejects the physician's greed for financial gains. Gregory and Percival propose a similar perspective by addressing the main qualities of a physician and asking the physician for ignoring his/her self-interest. However, Galen focuses on the learning of philosophy, while Gregory and Percival concentrate on gaining medical knowledge and skills. In terms of the commonality between the Hippocratic Oath and Gregory's and Percival's medical professionalism, it may be asserted that both approaches emphasize the benefit of patients, even in a paternalistic manner.

Even though the medical ethics literature recognizes Gregory's contribution, Percival's influence, particularly in the United States due to his impact on the American Medical Association's *Code of Medical Ethics*, is more visible.[38] Thomas Percival's work *Medical Ethics*, which was published in 1803, was the first source in the literature using the term *medical ethics*.[39] Gary S. Belkin deems *Medical Ethics* "as a milestone in the Western discussion of medical ethics," Ivan Waddington regards it as "an important break-point between ancient and modern medical ethics," and Robert M. Veatch considers it "the foundation of modern Anglo-American professional physician ethics."[40] Percival's *Medical Ethics* resulted from a specific conflict in the Manchester Infirmary among physicians, surgeons, and apothecaries. Therefore, it contained certain guidelines

to resolve the conflict by describing professional etiquettes and responsibilities of these professions in order to ensure a sustainable relationship.[41] For this reason, rather than physician-patient-based ethical problems, *Medical Ethics* was directed at the relationship between practitioners.[42] Nevertheless, it does not mean that Percival's work generated no effect on the general perspective of medical ethics and the patient-physician relationship. For instance, Veatch defines Percival's contribution as the replacement of "[t]he religious virtues of purity and holiness of the Hippocratic Oath" with "the virtues of the gentleman."[43]

Thomas Percival's work formulated medical ethics, which can also be called professional ethics of physicians, through portraying the physician's character, demonstrating the relationship among physicians, and defining the physician's behavior toward patients and the public.[44] Percival's ethics generated a tremendous effect, especially in the United States. In 1808, Boston Medical Society adapted Percival's professional ethics to forge a medical policy.[45] Similarly, in 1847, the American Medical Association (AMA) "establish[ed] uniform standards for professional education, training and conduct" by introducing *The Code of Medical Ethics*.[46] According to Veatch, the influence of Percival's ethics on the AMA's code of 1847 was unquestionable.[47] However, the AMA's Code of Medical Ethics encompassed some additional features. Percival's *Medical Ethics* consisted of four chapters: of professional conduct related to hospital or other medical charities, of professional conduct in private or general practice, of the conduct of physicians to apothecaries, and of professional duties in certain cases which require a knowledge of the law.[48] As the chapter titles indicate, *Medical Ethics* reveals the physician's professional conducts and duties without explicitly imposing any

responsibility on patients. However, AMA's *Code of Medical Ethics* also highlighted certain obligations of patients and the public to physicians. The introduction of the Code explained the components of medical ethics as "not only the duties, but, also, the rights of a physician."[49] The replacement of duties with duties plus rights indicates that medicine was no longer considered a unilateral duty, but a bilateral relationship. In other words, medicine transformed from a physician responsibilities-oriented reading into a physician and patient responsibilities-based understanding. This approach helped the development of patient rights as well in light of the rationale of the balance between duties and rights.

Percival's ethics launched a new era in medical ethics, which continued with the Code of 1847 and its subsequent revisions. This time created a medical professionalism-driven ethics. In this context, if the deontological Hippocratic Oath is counted as the first period and the virtue-based Galen ethics is regarded as the second period, the medical professionalism may be accepted as the third period in medical ethics. Even though this third period's professional standards brought about certain improvements in medical ethics, many factors forced the emergence of a new period in medical ethics: bioethics.

3.3 Bioethics Era

Both the Hippocratic Oath and Galen ethics draw a framework to describe how a physician should perform his profession without specifying a particular word or phrase to address the general structure they portray. However, Thomas Percival used the term *medical ethics* for the first time, to illustrate physicians and surgeons professional conduct, even though he personally had preferred using the term *medical jurisprudence*, but was convinced of ethics rather than jurisprudence by his friends.[50] The AMA's *Code of Medical Ethics* completely internalizes this term and describes it "as a branch of

general ethics … [and] identical with Medical Deontology" which indicates physicians' duties as well as physicians' rights.[51] As of the 19th century, medical ethics was utilized to display moral conduct in medicine. However, at the beginning of the 1970s, some scholars began using a new concept, *bioethics*, instead of *medical ethics*. This change was not merely a conceptual modification, but also a contextual paradigm shift. In this section, the circumstances behind this paradigm shift and the meaning of bioethics will be examined. Nevertheless, prior to exploring these issues, the discovery of the term *bioethics* will be elaborated in order to show the understanding of the discoverer/discoverers of this word.

3.3.1 Coining of Bioethics

In *Global Bioethics: An Introduction*, Henk ten Have declares researcher Van Rensselaer Potter as the person who discovered the word *bioethics*.[52] According to Robert Martensen, who cites from Warren T. Reich, it was Sargent Shriver coined the term *bioethics* in 1970.[53] However, Jose Roberto Goldim claims that the Protestant minister Fritz Jahr first used this word in German in 1927 and recognizes Van Rensselaer Potter as the first person who used the term in English.[54] Furthermore, in two different articles, "The Word "Bioethics": Its Birth and the Legacies of those Who Shaped It" and "The Word "Bioethics": The Struggle Over Its Earliest Meanings," Warren T. Reich also discusses the possibility of Andre Hellegers to be the one who invented the word *bioethics*.[55] In light of the historical chronology of events, there are two questions: whether the founders of the Kennedy Institute Sargent Shriver and Andre Hellegers were influenced by Van Rensselaer Potter's works and whether Van Rensselaer Potter was influenced by Fritz Jahr's arguments regarding the term *bioethics*.

Warren T. Reich's analysis demonstrates a sturdy clarification regarding Van Rensselaer Potter's, Sargent Shriver's, and Andre Hellegers's role in the invention of the word *bioethics* and their contribution to the development of bioethics.[56] Reich did not only rely on the literature and his individual assessment, but also had interviews with Van Rensselaer Potter and Sargent Shriver as well as Eunice Kennedy Shriver's memorandum. In the memorandum, Eunice Kennedy Shriver's pointed out her husband Sargent Shriver as the discoverer of the term *bioethics*, and Sargent Shriver affirmed this information during his interview with Reich. According to the information disclosed by Eunice Kennedy Shriver and confirmed by Sargent Shriver, Sargent Shriver had found *bioethics* as thinking about a term being able to represent the combination of biology and ethics when they had been planning to establish the Kennedy Institute, and Sargent Shriver had divulged this term to the people including Andre Hellegers who had been to Shrivers' house.[57]

The Kennedy Institute of Ethics, which was named as the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics at the beginning, was founded by the effort of Eunice Kennedy Shriver, Sargent Shriver, Edward M. Kennedy, Robert Henle, and Andre Hellegers as the founding director of the Institute.[58] During the preparation of establishing the Institute, as the Shrivers stated, the word *bioethics* could have invented by Sargent Shriver as a result of his endeavor to explore a term reflecting the Institution's comprehensive perspective. However, Reich provides two critical issues about the period prior to founding the Institute. First, none of the proposals nor the other documents concerning the establishment of the Institute including Andre Hellegers' initial proposal and the letter from Sargent Shriver to Andre Hellegers

had contained the word *bioethics*, "until it appear[ed] in a letter dated June 21, 1971, just ten days before the Institute opened on July 1, 1971."[59] Second, an article entitled *The New Genetics: Man Into Superman*, which was published as special section and cover page by *Time* magazine on April 19, 1971, assessed medical improvements and their ethical aspects and also mentioned Van Rensselaer Potter's book *Bioethics*.[60] Eunice Kennedy Shriver acknowledged that "she was familiar with that issue of *Time*, but both Sargent Shriver and Andre Hellegers were not aware of Potter's works and they heard nothing about the word *bioethics*.[61] Neither the issue of *Time* nor the matter of adding the term *bioethics* to the title of the Kennedy Institute ten days before its official establishment damages the credibility of the founders of the Kennedy Institute, in terms of coining the word *bioethics*, nor warrants ignoring their contribution to the flourishing of bioethics. Nevertheless, there are many coincidences present, one of which is using the exact wording of Potter. Potter explicitly uses the term bioethics as the combination of science and ethics. At the press conference declaring the opening of the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics, the same definition of bioethics is used. All these coincidences bring about certain questions whether the founders of the Institution were subconsciously influenced by Potter's works.[62]

Van Rensselaer Potter's article "Bioethics, the Science of Survival" was published by *Perspectives in Biology and Medicine* in the issue of Autumn 1970. This article was adapted from Potter's book *Bioethics: Bridge to the Future* which was published in January 1971.[63] In this context, prior to the announcement of initiating the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics,

Potter's article and book were already released, and in the issue of *Time* magazine dated April 19, 1971, the book was cited. These facts indicate that Sargent Shriver and Andre Hellegers may have been influenced by Potter's works, but not the alternative. Therefore, it is a rational argument to honor Potter as the person who coined the term *bioethics*. Nevertheless, the German Protestant pastor and ethicist Fritz Jahr who "had studied theology, philosophy, music, and history" has an article in a German journal, *Kosmos*, from 1927 which elaborates the word "Bio-Ethics [Bio-Ethik]" in order to demonstrate the ethical approach of human beings to all living beings.[64] There is no proven evidence that Potter was aware of Fritz Jahr's article and its concept of bioethics.[65] Additionally, as Hans-Martin Sass quoted from Jahr's article, Fritz Jahr accepted that bio-ethics was not a discovery of his time, but originated from previous works regarding human moral attitude and behavior towards animals and nature.[66] Jahr transformed Immanuel Kant's categorical imperative into bioethical imperative as "[r]espect every living being on principle as an end in itself and treat it as such if possible."[67] For this reason, due to Jahr's concentration on human beings' moral relationship not only among humans, but also with animals as well as with plants, Jahr's concept of bio-ethics is largely considered broader than Potter's stance on bioethics.[68] Regardless of Jahr's understanding of bioethics, he uses the word *bioethics* in academic studies almost a half-century prior to Potter's rediscovery of the same term.

Even though some sources distinguish Jahr's reading of bioethics from Potter's, by emphasizing the contextual broadness of Jahr's term, it remains unclear if such a conclusion can be reached. It appears that Jahr's bio-ethics and Potter's bioethics are virtually identical. Jahr regards bio-ethics as the formulation of moral duties which

require respecting and promoting the existence and survival of animals and plants. Nevertheless, Jahr does not object to "the proper utilization of animals" and plants.[69] In *Bioethics: Bridge to the Future*, Potter displays a similar approach to expound on bioethics. In the preface of the book, Potter explains the goal of the book as to suggest a bridge between science and humanities in order to ensure "the survival of the total ecosystem."[70] According to Potter, if animals and plants do not survive, human beings would not survive either because humans are dependent on nature. The survival can be achieved by creating an ethical relationship among humans, environment, animals, and plants through biological knowledge which refers to science and human values indicating ethics.[71] However, a main difference can be outlined between Jahr's and Potter's contextual frameworks by evaluating these two approaches from Kant's categorical imperative perspective. Jahr's position on other living beings including environment is to treat them as an end in themselves as much as possible. Whereas Potter's stance concerning the survival of animals, plants, and environment, is mostly a means for the survival of human beings.

In light of all above-mentioned points, it may be stated that the issue of addressing the founder of the term *bioethics* is a controversial matter. Nevertheless, this does not necessitate ignoring the role of Fritz Jahr, Van Rensselaer Potter, and the founders of the Kennedy Institute including Sargent Shriver and Andre Hellegers in the foundation and development of bioethics. Jahr's publication of 1927 in German, Bio-ethics [Bio-ethik]: A Review of the Ethical Relationship of Humans to Animals and Plants, illustrates Jahr's broad ethical analysis under the term *bioethics*. This fact makes Jahr the discoverer of the word *bioethics*. Goldim asserts that Jahr's work did not

engender any influence in academia and did not produce followers of his ideas.[72] Nonetheless, the presence of such a condition does not justify disregarding Jahr's work and his formulation of bioethics. Jahr should be recognized as the founder of the term *bioethics*. In this context, Potter is the rediscoverer of the word *bioethics* in a new era when scientific, technological, medical, political, and social dynamics were requiring a paradigm shift in medical ethics. Even though bioethics has flourished in the manner that Potter did not intend, this new concept and discipline has created a powerful impact in many areas including medicine, theology, and philosophy.[73] Furthermore, Potter's contribution to the emergence and development of global bioethics is another reason to honor Potter as a pioneer of the bioethics field.[74]

In terms of the contribution of Sargent Shriver and Andre Hellegers to the coining of term *bioethics*, the most appropriate way is to focus on the institutional effort rather than the individuals. The Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics used the word bioethics in its institutional title. Even though in few subsequent years the title was turned into the Kennedy Institute of Ethics, the initial title containing the word *bioethics* was an important step in the recognition of bioethics. Moreover, the Institute deserves to be deemed as the leading organization, with the Hastings Center, in the emergence of bioethics as a new discipline as well as in conducting, supporting, and promoting academic studies in bioethics.[75]

3.3.2 Bioethics: A New Discipline

Examining the literature to explore the concept and content of bioethics, there are three common points: bioethics is a new discipline; bioethics is a multidisciplinary field; and technological, social, political, and cultural changes in post-World War II period

which urged the emergence of bioethics.[76] When investigating the accuracy of these statements, a sturdy definition of bioethics must be provided. Bioethics consists of the prefix *bio* whose dictionary meaning refers to all living beings and the noun *ethics*, which is the study of morality illustrating what is morally right and wrong.[77] In this view, bioethics can be understood as a study looking at the morality of human actions towards all living beings. Fritz Jahr chiefly used bioethics in such a perspective.[78] Van Rensselaer Potter showed a similar approach to explain bioethics; he counted "biological knowledge," which covers knowledge about human beings, animals, plants, and physical environment, and "human values" as two components of bioethics in order to merge science and humanities.[79]

In the preface of the Hastings Center's report, *The Teaching of Bioethics*, Robert M. Veatch partly reflects Potter's "biological knowledge" view and delineates bioethics in a more specific manner as the combination of "biological ethics" and "medical ethics."[80] In light of Veatch's position, it is possible to assess bioethics as an evolutionary version of medical ethics. Both Jahr's and Potter's views were encompassing broad frameworks overly transcending the scope of the medical field. Thus, in his new book, entitled *Global Bioethics*, Potter highlights his dissatisfaction with the new way of bioethics which is diverted into a medicine-oriented direction, contrary to his intention and expectation.[81] To some extent, Potter holds Georgetown University responsible for the new track of bioethics and named this de facto situation as *medical bioethics*.[82] Potter implies the Kennedy Institute of Ethics by Georgetown University, but it was not only the Kennedy Institute interpreting bioethics in a healthcare context. For instance, in 1973, Daniel Callahan, from the Hastings Center, stated that "[w]hen we ask what the place of

bioethics might be, we, of course, need to know just what the problems are in medicine and biology which raise ethical questions and need ethical answers."[83] In *Encyclopedia Bioethics*, in 1995, Callahan examines bioethics through a broader outlook, mostly in light of Potter's wording, but also by regarding medicine and healthcare as the central point of bioethics with a scope containing many disciplines including biology, environmental studies, public policy, and social sciences.[84] Additionally, in the introduction of the encyclopedia, Warren Thomas Reich defines bioethics as "the systematic study of the moral dimensions—including moral vision, decisions, conduct, and policies—of the life sciences and healthcare, employing a variety of ethical methodologies in an interdisciplinary setting."[85] As a result, even though the interdisciplinary characteristic of bioethics is unanimously acknowledged, the contemporary reading of bioethics places this multidisciplinary feature within the sphere of medicine and health sciences.

In this view, considering bioethics a new discipline is meaningful but also an inadequate approach. It is meaningful because it denotes the study of morality not only in medicine, but also in all health-related areas including public health, health research, and environmental sciences. This approach is inadequate because bioethics is not a completely newly-discovered discipline, but an evolution of medical ethics. The scope and philosophical aspect of bioethics is much broader than of medical ethics. Either explaining the scope of bioethics by Potter's words as "biological knowledge" or by Reich's words as "life sciences," it is doubtless that bioethics indicates the relationship between ethics and all health-related sciences which overly transcend the scope of medical ethics.[86] Furthermore, rather than merely the physician's benevolence- and

professionalism-driven stance of medical ethics, bioethics is also grounded on individual autonomy and justice.[87] Nevertheless, none of these considerations exempts the heritage of medical ethics and its influence on bioethics. In this sense, it can be said that bioethics is a new discipline evolving from medical ethics.

The issue of being an interdisciplinary field also creates a connection between medical ethics and bioethics. Of course, bioethics is associated with more academic fields, but medical ethics has been a multidisciplinary study since the time of Hippocrates. For example, Galen asked physicians to also be philosophers which did not mean merely learning philosophy, but also acquiring the knowledge of all relevant disciplines including astronomy, biology, and psychology, by expressing the necessity of knowing "the logical, the physical, and the ethical" parts of philosophy.[88] From this perspective, the interdisciplinary characteristic of medical ethics and bioethics stems from the nature of the field. However, as Warren Thomas Reich accentuates in his definition, bioethics has brought a systematic analysis of morality in medicine with the relationship among all pertinent disciplines.[89] Moreover, maybe the relationship between medicine and other fields would have been regarded as an ideal or virtue in the past, whereas this multidisciplinary relationship is deemed an obligation in the era of bioethics.

The third matter is related to the circumstances which urged the emergence of bioethics. The earliest use of the term *bioethics* (excluding Jahr's utilization) appeared at the beginning of the 1970s, started by Potter's work and continued by the Kennedy Institute of Ethics and other institutions and scholars.[90] However, the factors requesting a paradigm shift in medical ethics go back to far before the 1970s. The medical, technological, legal, social, and political problems and changes, particularly in the post-

World War II period, brought about the need for a new freedom-, justice-, and equity-based approach in medicine, research, and public health.[91] The invention of penicillin in 1928, the introduction of cancer chemotherapy in 1947, the discovery of the polio vaccine in 1949, the development of cardiovascular resuscitation in 1958, and similar improvements in medicine and medical technology gave healthcare professionals the opportunity to have a greater role in life-sustaining and general medical interventions.[92] Atrocious medical research studies, such as the Nazi medical experiments, the Jewish Chronic Disease Hospital experiment, and the Tuskegee Syphilis Study, and their revelations provoked international and domestic outcry and demand to regulate research ethics.[93] The formulation of the Nuremberg Code and the Declaration of Helsinki as well as the establishment of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (the National Commission) and the President's Commission for the Study of Ethical Problems in Medicine and Bioethical and Behavioral Research (the President's Commission) in the United States resulted from these scandalous instances of research with human subjects.[94] Moreover, human rights movements, gender equality-based social requests, and individuality-oriented political developments raised the demand for personal autonomy.[95] Additionally, legal cases in the United States like Roe v. Wade, Karen Ann Quinlan, and Baby Doe significantly gave public attention to bioethical issues.[96]

As the result of several medical, technological, social, political, and legal issues, bioethics has flourished as a new multidisciplinary field. However, like the other two points, the matter of bioethics emerging reasons should not be evaluated without the history of medical ethics. It is believed that all these developments are parts of the

evolution in medical ethics. It is obvious that post-World War II incidents, discoveries, and challenges accelerated the pace of this evolution, but without the ethics of Hippocrates, the contribution of Galen ethics, and the professionalism–centered Percival's aspect, bioethics would not have bloomed in a five-decade period. Nonetheless, in the evolutionary development of medical ethics, bioethics denotes the most substantial change, hence this last transformation may be named as a paradigm shift rather than a simple change.

3.4 Bioethics Education

The literature has largely regarded bioethics as a discipline since the 1970s. In 1973, Daniel Callahan questioned whether bioethics was a discipline and underscored some problems, such as "[t]he lack of general acceptance, disciplinary standards, criteria of excellence and clear pedagogical and evaluative norms" of the field to be counted as a discipline.[97] Callahan concluded that becoming a discipline chiefly depends on whether bioethics produces practical solutions to the challenges physicians and scientists experience. By his conclusion, Callahan addresses the practical outcomes of being a discipline. However, prior to expecting such outcomes, there must be pedagogical standards, theories, methods, and concepts facilitating the teaching and learning of the discipline-related knowledge and practices.[98] In other words, it would be difficult to accept a particular area of study as a discipline without its teaching and learning. In this context, looking at the history of bioethics education would provide information about the emergence of bioethics as a discipline.

3.4.1 Teaching Bioethics

Robert M. Arnold and Lachlan Forrow claim that the teaching of medical ethics has existed since the teaching of medicine, maybe not as an independent ethics course, but as an "apprenticeship model."[99] Albert R. Jonsen says that in the 19th century, many medical curricula were encompassing some lectures to teach the moral responsibilities of physicians.[100] Nevertheless, the systematic teaching of ethics in medical schools began by the 1970s. Shimon M. Glick recalls his medical school education in the United States at the beginning of the 1950s and states that there was neither a medical ethics course nor any clues about the teaching of ethics.[101] Similarly, Howard Brody points out the survey carried out by the Hastings Center in 1974 to show the lack of formal teaching of ethics in medical schools in the United States by emphasizing how few physicians had formal ethics education.[102] Moreover, the survey conducted by the Hastings Center in 1974, found that 91% of medical schools in the United States (107 schools participated in the survey) provided a certain form of medical ethics education; 6% of them as required courses, 44% of them as elective courses, and 50% of them as integrating medical ethics into other courses or lecture series.[103] Although the rate of ethics teaching in medical schools appears high, when the percentage of schools without required courses (94%) is taken into consideration, the shortage of mandatory bioethics teaching can be noticed. Furthermore, as Jonsen (1989) noted, besides the absence of formal courses in the 1970s, there was also a lack of bioethics literature.[104]

The founding of the Hastings Center (Institute of Society, Ethics and the Life Sciences) in 1969 and the Kennedy Institute (The Joseph and Rose Kennedy Center for the Study of Human Reproduction and Bioethics) in 1971 created significant

contributions to the development of bioethics and bioethics education, through assembling bioethicists, supporting research studies, forming a bioethics literature, and organizing educational activities.[105] The Hastings Center's Report of the Commission on the Teaching of Bioethics is one of these contributions providing a comprehensive framework for bioethics teaching. The Report aims to determine standards in teaching bioethics. In order to do that, the Report clarifies four main subjects surrounding bioethics teaching: its goals, patterns, scope, and priorities. The Report not only focuses on teaching bioethics in medical or nursing schools, but also concentrates on a broad perspective from elementary schools to graduate schools, from nonmedical professional schools to adult education.[106]

Ethics education in medical schools remarkably increased in the 1980s and 1990s. As the survey of the Hastings Center (1976) indicates, the percentage of medical schools with required medical ethics courses had been only 6% in 1974. However, another study shows that the percentage of separate, required medical ethics courses in surveyed American medical schools increased to about 34% in 1989.[107] Additionally, the study carried out in 2000 by Lisa Soleymani Lehmann and her colleagues illustrates that 78% of responding medical schools (85 American and 6 Canadian medical schools) taught ethics as part of other required preclinical courses.[108] In other words, of the schools surveyed, in 1974 6%, in 1989 34%, and in 2000 78% of medical schools provided mandatory ethics education, either as a separate course or as an integrated course into other courses. This noticeable growth in bioethics teaching has not been limited to medical schools. A data analysis-based study done by Lisa M. Lee and Frances A. McCarty proves how quickly bioethics education has bloomed in postsecondary degrees

in the last decade. The study reveals that between 2003 and 2013, 173 bachelor's degrees, 1723 master's degrees, 156 doctoral degrees, and 262 certificates in bioethics and applied ethics were earned in the United States. The study also illustrates that from 2003 to 2013 the number of institutions offering bachelor's degrees, master's degrees, doctoral degrees, and certificates in bioethics and applied ethics in the United States increased from 1 to 10, from 4 to 30, from 2 to 6, and from 1 to 14, respectively.[109]

The burgeoning interest in bioethics since the 1970s has not merely occurred in the United States, but almost across the world. Henk ten Have gives some examples to specify how rapidly ethics education spread in certain countries and regions in the 1980s and 1990s.[110] Additionally, ten Have expands on the growth of bioethics education by six phenomena. Firstly, over the course of time, medical ethics in undergraduate studies has also become a part of graduate curricula, clinical ethics, and other programs. Secondly, besides medical schools, other healthcare professional schools have begun teaching bioethics. Thirdly, different academic disciplines including biology and life sciences have engaged in bioethics education. Fourthly, learning bioethics has become obligatory for scientists and researchers. Fifthly, bioethics has attracted the attention of the public and policy-makers. Finally, online course facilities have brought about the opportunity to more people to receive bioethics education.[111] Nevertheless, the remarkably increasing expansion in bioethics education has also led to some problems which can be summarized as the lack of standardization in or disagreement on goals of bioethics education, teaching methods, course hours, course content, and evaluation of teaching bioethics.[112] Nonetheless, it should be considered acceptable to experience certain challenges in such a promptly growing multidisciplinary field. Furthermore, similar to the

emergence of bioethics, bioethics education has also been developing through the effort of individual scholars, local and national institutions such as the Hastings Center and the Kennedy Institute, and international organizations like United Nations Educational, Scientific and Cultural Organization (UNESCO). It is already possible to find many academic studies, educational activities, associations, and journals on bioethics education as the result of increasing interest in teaching bioethics, but most likely, in the next few decades, there will be more scholars and studies focusing on the abovementioned problems in bioethics education.[113]

3.4.2 Three Works on Bioethics Education

Bioethics was established on the heritage of medical ethics. However, as a new term and discipline, it has a history that can be traced to five decades. Nonetheless, in this short period, bioethics has had an enormous development with numerous bioethicists, impressive literature, abundant academic journals, and bioethics centers and intuitions. The extraordinary growth has created positive impacts on bioethics education. From this perspective, in this subsection three notable works will be highlighted to demonstrate some institutional endeavors on bioethics education: the Hastings Center's *Report of the Commission on the Teaching of Bioethics (The Teaching of Bioethics)*; UNESCO's *Bioethics Core Curriculum*; and the Presidential Commission for the Study of Bioethical Issues' *Bioethics for Every Generation*. These three works do not only indicate particular recommendations to describe how to teach bioethics, but also prove the involvement of different players in bioethics as a nonprofit research institution, an international organization, and a policy maker's commission.

The Hastings Center's report, *The Teaching of Bioethics,* is the first all-inclusive work devoted to teaching bioethics. The report was published in 1976, just five years after the coining or rediscovery of the word *bioethics*. The report reflects of the Center's commitment to support bioethics education. The report refers to a serious need for how to organize an effective bioethics teaching because of the lack of experience in the field concerning a teaching method, content, evaluation, and materials. For this reason, the report aimed to assist in all stakeholders in bioethics teaching; from teachers to school administrators and from relevant public institutions to pertinent associations. The commission, which consisted of 9 distinguished scholars from different universities and different disciplines all of whom had had medical ethics or bioethics teaching background, was appointed in 1973. Even though the commission initially thought about using the phrase *medical ethics*, they eventually decided to use term *bioethics* due to its broad scope encompassing both *medical ethics* and *biological ethics*.[114]

The report comprises three chapters. In comparison with the second part of the report, the first and third parts largely give generic information. The first one elaborates three issues: providing a general view on the concept of bioethics; clarifying the goals of bioethics teaching; and discussing the patterns of bioethics teaching. This section asks some questions, such as who should teach bioethics. It also generates some arguments to illustrate an overall proposed structure for bioethics teaching. The third chapter spotlights priorities for bioethics education to fulfill the determined goals and facilitate the development of bioethics as a multidisciplinary field.[115]

The second part constitutes the main section of the report which produces details about the scope of bioethics teaching. This part specifies teaching bioethics under eight

particular levels or programs: elementary and secondary schools; undergraduate education; medical schools; nursing schools; nonmedical professional schools; continuing professional education in bioethics outside degree programs; adult education; and M.A and Ph.D. programs. Each of these levels of education is assessed by evaluating the current situation of the program and making recommendations regarding goals, curriculum or course structure, teaching formats, administrative organization, needs and priorities, and teaching qualifications.[116] In this view, in addition to creating practical information about how to formulate almost every step of teaching bioethics, the report proves that the matter of teaching bioethics is not only relevant to health-related schools or undergraduate and graduate level education, but also associated with every educational stage from elementary schools to Ph.D. programs.

UNESCO's *Bioethics Core Curriculum* is another prominent source delineating bioethics education. As an international organization, UNESCO has actively been involved in the bioethics field to improve, support, and disseminate bioethics education across the world.[117] In 2005, the *Universal Declaration of Bioethics and Human Rights*, which was established on eight goals and fifteen specific principles, was accepted by 191 member states of UNESCO.[118] Article 25 of the Declaration assigns UNESCO to "promote and disseminate the principles set out in this Declaration" and urges UNESCO to "seek the help and assistance of the Intergovernmental Bioethics Committee (IGBC) and the International Bioethics Committee (IBC)" to fulfill its commitment.[119] In this view, *the Bioethics Core Curriculum*, which consists of two different sections, is the consequence of this particular task and UNESCO's commitment to supervise, endorse, and reinforce bioethics education.

The first section of the Curriculum, which provides a sample syllabus, was published in 2008. The approach and principles of the Declaration shape the syllabus; after two introductory units concerning ethics and bioethics, the syllabus devotes a unit to each principle of the Declaration. The syllabus particularly aims to facilitate bioethics education in areas where there is a lack of teaching experience. The primary target groups of the syllabus is medical students and students in the clinical stage. Moreover, it intends to guide teaching bioethics in all health-related schools including nursing schools, other disciplines like law and philosophy; healthcare professionals' vocational training and continuing education; and ethics committee members' educational programs.[120] The second section of the Curriculum, which identifies study materials, was published in 2011. The second section is the complementary part of the syllabus indicating specific methods and sources to teach the topics taking part in the syllabus in accordance with the course learning objectives.[121]

In light of the goal to promote and disseminate bioethics all over the world, the Curriculum can play an important role in countries or fields where bioethics education has newly been introduced. Everyone in everywhere could benefit from it, but it would be more useful in areas where bioethics education in a nascent stage. In comparison with the Hasting Center's *Teaching of Bioethics*, UNESCO's *Bioethics Core Curriculum* is more specific. *The Teaching of Bioethics* draws a general framework about how to teach bioethics to different groups of people at different educational levels, when separately appraising bioethics education for each group, without addressing what exactly to teach. However, the *Bioethics Core Curriculum* formulates a syllabus with determined methods and materials for each unit in order to explicitly show what and how to teach. The

Curriculum produces only one syllabus and claims that it can be applied to distinct educational levels and programs. Certain advantages, as well as disadvantages, may be listed for both works. Nevertheless, in the case of forming a new bioethics program, utilizing certain characteristics of both and combining the comprehensive perspective and scope of the *Teaching of Bioethics* with specific, but also the global aspect of the *Bioethics Core Curriculum* can prove beneficial.

The third work on bioethics education is *Bioethics for Every Generations* created by the Presidential Commission for the Study of Bioethical Issues (Bioethics Commission). This commission is the seventh and the last commission of the series of the presidential commissions in the United States. The first of which was the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research established in 1974. The Bioethics Commission was assigned by President Barack Obama in 2009.[122] *Bioethics for Every Generation* which encompasses eight recommendations "to increase and improve the use of democratic deliberation and ethics education in order to enhance complex decision making in bioethics and health, science, and technology policy at all levels," was published in 2016 as the final report of the Bioethics Commission.[123]

The main characteristic of the report is to evaluate bioethics and bioethics education in light of democratic deliberation. Which is defined as the process of an "inclusive and respectful debate" among all stakeholders to achieve "collaborative decision making" in order to generate better outcomes.[124] In this sense, it is possible to assert that the report represents a political attitude towards bioethics due to its approach in gauging ethical decisions with the political concept of democracy. Another essential

feature of the report is to separately investigate three phrases: education of bioethicists, bioethics education, and ethics education. It also assesses bioethics education as a part of ethics education. For this reason, rather than bioethics education, the report chiefly concentrates on the implementation of ethics education.[125] The attention to ethics education, instead of bioethics education, may result from the perspective of the report to disseminate ethics, as a broader concept, across a lifespan. *The Teaching of Bioethics* has a similar view in respect to demonstrating a lifespan approach. *The Teaching of Bioethics* and *Bioethics for Every Generation* reflect the same assumption that bioethics education is a lifespan phenomenon. However, *The Teaching of Bioethics* utilizes the term *bioethics*, not *ethics*, even when elaborating education in elementary and secondary schools.[126] Even though the report's stance on bioethics education may be deemed inadequate, the report's recommendations to guide, support, and develop bioethics education are valuable to recognize the need for bioethics education.[127]

3.5 Conclusion

In light of the current literature, it is Fritz Jahr who first used the term *bioethics*, as bio-ethik, in German in 1927. However, Van Rensselaer Potter is the first one to utilize this word in English in an era when medical, technological, political, and legal developments, scandals, or incidents pushed the emergence of bioethics. As a new academic discipline, bioethics is an interdisciplinary field representing and evolutionary change in medical ethics. The paternalistic and religious characteristics of the Hippocratic Oath, the virtuous physician-centered stance of Galen ethics, and the physician's duties and rights-based professional view of Percival ethics were evolved into autonomy- and justice-oriented bioethics. Besides the focus of medical ethics on physician-patient

relationships, bioethics also concentrates on health research, public health, and environmental issues.

The post-World War II incidents and developments facilitated the growth of bioethics. However, the flourishing of bioethics also created a serious need for bioethics education. In 1973, the Hastings Center established a commission to formulate a framework for teaching bioethics. Furthermore, as an international organization, UNESCO and as a political initiative, the presidential commissions in the United States have made significant efforts, not merely to disseminate new bioethical values, rules, and principles, but also promote and enhance bioethics education. As the results of these institutional supports, individual scholars' efforts, and high interest in bioethical issues, today the study of bioethics denotes a discipline with numerous teaching institutions, well-educated bioethicists, academic journals, as well as other publications across the world.

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[115] The Hastings Center, *The Teaching of Bioethics* (New York: The Hastings Center, 1976), 1-13, 61-69.

[116] The Hastings Center, *The Teaching of Bioethics* (New York: The Hastings Center, 1976), 14-60.

[117] "Bioethics Education Programme," UNESCO, accessed October 2, 2017, http://www.unesco.org/new/en/jakarta/social-and-human-sciences/bioethics-education-programme/.

[118] UNESCO, *Bioethics Core Curriculum: Section 1: Syllabus Ethics Education Programme* (Paris: UNESCO, 2008), 3.

[119] Henk A.M.J. ten Have (eds.), *the UNESCO Universal Declaration on Bioethics and Human Rights. Background, Principles and Application* (UNESCO Publishing, Paris, 2009), 365.

[120] UNESCO, *Bioethics Core Curriculum: Section 1: Syllabus Ethics Education Programme* (Paris: UNESCO, 2008), 2-3.

[121] UNESCO, *Bioethics Core Curriculum: Section 2: Study Materials Ethics Education Programme* (Paris: UNESCO, 2011), 2-10.

[122] "History of Bioethics Commissions," The Presidential Commission for the Study of Bioethical Issues, accessed October 4, 2017, https://bioethicsarchive.georgetown.edu/pcsbi/history.html.

[123] Presidential Commission for the Study of Bioethical Issues, *Bioethics for Every Generations*: *Deliberation and Education in Health, Science, and Technology* (Washington D.C.: Presidential Commission for the Study of Bioethical Issues, 2016), v, 18.

[124] Presidential Commission for the Study of Bioethical Issues, *Bioethics for Every Generations*: *Deliberation and Education in Health, Science, and Technology* (Washington D.C.: Presidential Commission for the Study of Bioethical Issues, 2016), 22.

[125] Presidential Commission for the Study of Bioethical Issues, *Bioethics for Every Generations*: *Deliberation and Education in Health, Science, and Technology* (Washington D.C.: Presidential Commission for the Study of Bioethical Issues, 2016), 54-76.

[126] The Hastings Center, *The Teaching of Bioethics* (New York: The Hastings Center, 1976), 14-19.

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4 Chapter - Determining the Goals of Ethics Education[3]

4.1 Introduction

Ethics education is an essential concept associated with almost all academic fields including healthcare. Many research studies demonstrate that ethics education improves ethical sensitivity, knowledge, awareness, and judgment. However, there is not a consensus on the goal, scope, and method of teaching ethics.[1] Furthermore, quality in ethics education and the measurement of quality are some other issues which require more academic studies to settle a general agreement. It is believed that it would not be feasible to establish a solid theoretical foundation of ethics education without specifying its objectives. Therefore, deciding what the goal/goals of ethics education is/are would be the first and foremost step to create a concrete background to determine the scope and method as well as quality standards and indicators of ethics education. In this sense, the aim of this chapter is to underscore the importance of ethics education in healthcare and draw a general framework regarding the goals of ethics education from a normative perspective. In this sense, the chapter begins with elaborating on the concepts of ethics and education to clarify what these terms imply. It will continue by explaining the notion and some approaches of teaching ethics and discussing the goals of ethics education. The

[3] As an extended version, this chapter was retrieved from "A Normative Analysis to Determine the Goals of Ethics Education through Utilizing Three Approaches: Rational Moral Education, Ethical Acculturation, and Learning Throughout Life" by Ercan Avci, *International Journal of Ethics Education* 2 (2017): 125-145. The copyright agreement gives the author the right to use his article in his dissertation.

chapter will conclude by highlighting the importance of strengthening cultural competence through ethics education.

4.2 Ethics and Education

The term *ethics education* is a phrase originating from two words: ethics and education. Though ethics education refers to the teaching of ethics, examining the components of the phrase as ethics and education would make the conceptual structure more understandable by clarifying the meaning and components of these words. However, both ethics and education are broad terms which include many theoretical elements, views, and insights. In this chapter, the terms ethics and education will be succinctly studied to explain what they imply. For this reason, the historical and philosophical emergence and background of these terms are beyond the scope of this chapter.

4.2.1 Ethics and Morality

As they grow, children learn societal values from their parents and society, as well as social, educational, and religious institutions. Individuals and communities usually strive to pass on their own values to the new members of the society or want to raise them with certain values in order to contribute to their moral development. However, this mostly happens through a long and slow continuum. For instance, when a parent realizes that the child has hidden something from him/her due to the fear of any consequences of telling the truth which the child envisions, the parent encourages him/her to tell the truth without worrying about the results of the disclosure. Nonetheless, based on the author's own experience, urging children to tell the truth is not sufficient because they desire to be persuaded through convincing explanations to clarify why they

should tell the truth or not. For this reason, analyzing the moral aspect of conduct is extremely important in determining what to do or not to do and why to do or not to do it.[2]

Many philosophers and authors have held discussions regarding the relationship between morality and ethics, some of whom acknowledge these terms as synonyms, while some others reveal certain distinctions between these terms. Even though it is believed that morality differs from ethics in some points, such as dissimilarities between their origins and scopes, to some extent, morality and ethics may be considered interchangeable.[3] However, because of widespread use of these words (ethics, ethical, morality, moral, morally), in the present chapter, it would be beneficial to briefly compare morality with ethics and highlight their leading features to elucidate the conceptual framework without plunging into a deep philosophical debate.

The Cambridge Dictionary delineates morality as "a personal or social set of standards for good or bad behavior and character, or the quality of being right and honest," and designates ethics as "the study of what is morally right and wrong, or a set of beliefs about what is morally right and wrong."[4] From this perspective, morality exhibits some standards to decide which personal or social attitudes and behaviors are good or bad. In other words, morality contains a guideline gauging the acceptability of personal and social conduct. The dictionary describes ethics by utilizing morality and regarding it as a study which determines what is morally right or wrong. The lexical definition of these terms indicates that morality refers to a set of standards demonstrating what is good and bad, whereas ethics shows what is morally right and wrong. Therefore, ethics is a study that uses the standards identified by morality to explain the rightness and wrongness of attitudes and behaviors.

According to Jeremy Bendik-Keymer, ethics is a term older and broader than morality; the former goes back to Ancient Greek, whereas the latter comes from a Judeo-Christian background. In accordance with Bendik-Keymer's approach, ethics focuses on the question of "how I should live," while morality looks for the answers of "how I must relate" and "how I am to relate to others as a human being."[5] Bernard Gert describes morality as "an informal public system applying to all rational persons, governing behavior that affects others, and includes what are commonly known as the moral rules, ideals, and virtues and has the lessening of evil or harm as its goal."[6] Karen L. Rich accepts ethics as "a philosophical discipline of study" and defines it as "a systematic approach to understanding, analyzing, and distinguishing matters of right and wrong, good and bad, and admirable and deplorable as they relate to the well-being of and the relationship among sentient beings."[7] From all these explanations, it can be stated that even though there is a close connection between ethics and morality due to their common focus on deciding what is right and wrong, some differences may be noted.

Morality is a combination of rules, values, and standards shaping the rightness and wrongness of individual and social conduct. However, the universality of morality is a controversial issue. It is obvious that cultural and religious factors influence morality and its ingredients. In this sense, each culture and religion carries some unique moral rules, values, and standards.[8] Although some authors, like Bernard Gert, claim the possibility of presenting a common morality, it is believed that an attempt to generate a universal morality is not feasible as well as not needed.[9] Of course, a common definition of morality may be established. However, in the case of focusing on moral rules and values to build moral systems, certain differences would likely be encountered.[10] There

can be many moral norms accepted by almost all moral systems, such as not lying, not harming, and helping others, but this situation does not prove there is an exact similarity among all moral systems. As Gert emphasizes, mitigating evil and harm may be regarded as a goal of morality.[11] Nonetheless, dissimilarities in the description of evil and harm might naturally bring about distinctions among different moral systems.

On the other hand, ethics is the study of moral philosophy analyzing moral acceptability of attitudes and behaviors and producing answers to the question of "how I/we should live" by explaining the rationale of the answers.[12] As a study, ethics employs moral standards and justifies its solutions by implementing moral rules and virtues. In this context, ethics includes theories, models, codes, and principles to elucidate morally right and wrong acts and behaviors. The subjectivity of moral standards on which ethics is built may make the objectivity and universality of ethics questionable. Nevertheless, because of its essential characteristic as the study of moral philosophy, ethics has to scrutinize and legitimize its "positions through logical, theoretically based arguments."[13] Therefore, different branches of ethics or different ethical approaches may rely on distinct moral rules and values and reach distinct conclusions. However, the study of these differences has to be conducted in a scholarly and rational manner. From this perspective, in this chapter, ethics is defined as *the moral philosophy analyzing moral standards and values to determine what is morally right and wrong and providing answers to the questions: "How should I/we live and why?" as well as "What should I/we do and why?" in light of the aim of minimizing evil and maximizing good*. (The first-person singular, I, is applicable to individual cases, whereas the first-person plural is pertinent to social moral analyses.)

4.2.2 Education

The second component of the phrase *ethics education* is education. Education is considered to be the best way to promote individual and communal development and the most effective remedy for overcoming many problems, such as ignorance, disparity, and poverty.[14] For that reason, education has the potential to produce fascinating outcomes and outputs on both an individual and public level. However, education is not a magical pill that generates fruitful results by itself. The presence of education does not guarantee the solutions of individual and social problems, but good practices could help to alleviate them.[15] Additionally, without clearly defining education and specifying its goals, it might be difficult to make any comment about the productivity of education.

The dictionary describes education as "the process of teaching or learning."[16] This definition reveals two aspects of education: teaching and learning. Teaching is a concept indicating that a teacher provides the knowledge of something to someone. In other words, the term *teaching* demonstrates the effort of a teacher to give knowledge to someone. Although the activity of teaching is intended to enlighten, edify and instruct learners, this process does not ensure that the learners acquire the provided knowledge. A teacher may make his/her best effort in order to inform and train someone without achieving this.[17] However, learning is the other aspect of education focusing on what the learner gains. Learning requires obtaining certain knowledge and skills with "some understanding of principles, of the 'reason why' of things."[18] According to R.S. Peters, education is a process that not only provides the opportunity to possess knowledge, but also requires understanding conceptual qualifications.[19] Hirst and Peters state that education "suggests not only that what develops in someone is valuable but also that it

involves the development of knowledge and understanding."[20] Hirst and Peters explain education as the process of possessing knowledge and highlight the purpose of education as "the development of desirable qualities in people."[21] The phrase 'desirable qualities' seems to be too obscure due to the ambiguity in the meaning of desirability and the question of 'being desired by whom.' For this reason, it is believed that expounding on the goal of education as 'developing knowledge and skills' might be more suitable. In some cases, increasing knowledge does not make sense unless the gained knowledge leads to promoting the relevant skills. For instance, having the knowledge of brain surgery does not make a physician a surgeon per se. The physician must also transform this knowledge into surgical skills by training and practicing processes. Therefore, improving skills is a crucial purpose that should be evaluated in the scope of education. Thus the Delors Report acknowledges the significance of improving skills besides knowledge in the process of education.[22] From these perspectives, in this chapter, education is described as *the process of improving the learner's knowledge and skills as well as boosting the learner's cognitive development regarding the acquired knowledge and skills*.

Aside from concisely exploring the definition of education, it would be useful to examine primary approaches to determine which is most appropriate for ethics education. The World Bank and the United Nations Educational, Scientific, and Cultural Organization (UNESCO) are two international organizations promoting education through their own perspectives. These institutions' views on education bring about two different approaches concerning how to provide educational services and how to improve

the efficiency of education. The World Bank's position represents the economist approach of education, while the UNESCO's viewpoint denotes the humanist approach.[23]

The World Bank considers education one of the most essential and effective tools in guaranteeing economic growth, peace, and stability as well as decreasing poverty, gender inequality, and economic disparity. In addition, the World Bank provides financial and technical support to requesting countries to "ensure inclusive and equitable quality education and promote lifelong learning opportunities for all."[24] The World Bank uses a program called Results-Based Financing (RBF) to increase demand for schooling, expand female students participation in school, maintain the number of enrolled students, and boost teaching and learning in countries in which the program is applied. Therefore, the Bank measures the success of the programs by gauging quantitative outcomes, such as schooling, enrollment, and retention percentages.[25] The focus of the Bank is mainly on the developing countries' educational systems and their challenges involving low schooling rates, inequalities against girls, and poor quality in teaching and learning in terms of acquiring knowledge and basic skills.[26] For this reason, it might be difficult to deem this approach a convenient model from which to borrow aspects for the shaping of ethics education.

UNESCO shares the World Bank's vision for education: to "[e]nsure inclusive and equitable quality education and promote lifelong learning opportunities for all."[27] However, the World Bank's focus on human capital, economic growth, and quantitative appraisal leaves educational processes, human development, and human rights to UNESCO's approach.[28] The Bank emphasizes the importance of education by highlighting its functions as "reducing poverty, raising incomes and resilience in the face

of crises, and promoting economic growth and shared prosperity" as well as ensuring "sustained investment in human capital."[29] Contrary to the World Bank's economic concerns-based approach, UNESCO puts stress on the humanistic aspect of education and details the ability of education to "empower learners of all ages and equip them with values, knowledge and skills that are based on and instill respect for democracy, human rights, social justice, cultural diversity, gender equality and environmental sustainability."[30] This situation demonstrates that even though both approaches have the same vision of education, the dissimilarities in their emphases, assessments, and expectations remarkably differentiate one from the other.

The Delors Report (*Learning: The Treasure Within*) of the International Commission on Education for the Twenty-first Century, which was prepared by UNESCO and published in 1996, is an outstanding work showing UNESCO's view on education. Furthermore, "the Delors Report is widely considered to be a key international reference for the conceptualization of education and learning."[31] The Report not only defines education as "an ongoing process of improving knowledge and skills," but also broadens its domain to "an exceptional means of bringing about personal development and building relationships among individuals, groups and nations."[32] This position expands the sphere of education as well as gives specific tasks to achieve, like establishing and enhancing relationships among people in all levels of societies and nations. Of course, each educational activity does not carry the potential to accomplish such broad social goals, but this perspective gives the chance to grasp the humanistic function of education and its positive impact on relationships among individuals, groups, and nations. The Report reifies this comprehensive perspective into four pillars in light of

the concept of "learning throughout life:" learning to know; learning to do; learning to be; and learning to live together.[33]

Though the Report explains its vision with four pillars, it particularly accentuates the priority of the pillar *learning to live together*. This point highlights how the Commission went beyond the traditional role of education as 'the possession of knowledge and skills.' *Learning to live together* requires recognizing historical, cultural, and religious values of individuals, groups, and nations and developing appropriate methods to wisely administer problems coming from the aforementioned differences in a peaceful manner. This pillar suggests respecting and sustaining individuals' personal and social values rather than converting one's tradition, religion, or style of life into the dominant one. Due to the difficulty of fulfilling the requirements of this pillar, the Report questions whether it is unrealistic to have such high ideals. However, the Commission admits that this situation is "a necessary Utopia" to overcome "a dangerous cycle sustained by cynicism or by resignation."[34] It is obvious that educating individuals in accordance with this pillar is not an easy task, but without doing so, the thought of creating a peaceful world would remain a utopian dream.

Learning to know is about the acquisition of knowledge of different subjects according to scientific, economic, and social necessities. *Learning to know* represents the classical aspect of education as possessing knowledge. The third pillar is *learning to do* which encompasses boosting certain skills for doing a job. Working is one of the major activities of human beings, and it requires obtaining pertinent qualities and skills. Therefore, the pillar of *learning to do* denotes getting or improving relevant vocational competencies to be able to do a job and cope with occupational requirements under the

circumstances of rapid changes and unexpected conditions. The last pillar of learning throughout life is *learning to be* which relates to personal development. This pillar demands the exploration and utilization of personal capabilities, such as "memory, reasoning power, imagination, physical ability, aesthetic sense, the aptitude to communicate with others and the natural charisma of the group leader."[35] In this sense, education does not merely imply the gain of something from outside of the person, but also entails discovering the person's internal abilities.

As a result, in the case of comparing the Delors Report's definition of education with its pillars, it may be deduced that:

- 'Improving knowledge and skills' represents *learning to know* and *learning to do*,

- 'Bringing about personal development' denotes *learning to be*, and

- 'Building relationships among individuals, groups, and nations' indicates *learning to live together*.

It is believed that this humanistic approach of education provides an all-inclusive and meaningful insight into learning, emphasizes the importance of understanding cultural, religious, and political differences, and demonstrates the necessity of finding peaceful ways to live together. In particular, the issue of *learning to live together* is an exceptional point for being able to manage the challenges and conflicts of a multicultural world as well as drawing a conceptual framework for ethics education. This is the case because the reality is that the existing diversity in cultural, religious, and philosophical viewpoints generates several distinct moral values, and compromising these differences

requires a well-educated as well as a receptive mindset and ethical outlook. However, a description of education in light of the aforementioned four pillars may burden the process of learning with the concern of being overly utopian. Nevertheless, defining education as 'an ongoing process of improving knowledge and skills' according to the pillars of *learning to know* and *learning to do*, and recognizing the other two pillars, *learning to be* and *learning to live together*, as the goals of education may assuage this apprehension.

4.3 Ethics Education

In the first section, the concepts of ethics and education have been evaluated. Ethics was described as the moral philosophy analyzing moral standards and values to determine what is morally right and wrong and providing answers to the questions: "How should I/we live and why?" as well as "What should I/we do and why?" in light of the aim of minimizing evil and maximizing good. Education, on the other hand, was defined as the process of improving the learner's knowledge and skills as well as boosting the learner's cognitive development regarding the acquired knowledge and skills. In light of these definitions, in this section, the notion and some approaches of ethics education will be examined.

4.3.1 The Concept of Ethics Education

UNESCO is one of the few international organizations closely engaged in ethics education. UNESCO's first involvement in teaching ethics was the World Conference on Science and the Use of Scientific Knowledge in 1999. In the Declaration of the Conference, all scientists were invited to follow ethical codes and standards in light of international human rights. Moreover, the Declaration recommended adding ethics to

science curricula.[36] As a result of UNESCO's continued interest and the member countries' request, ethics and teaching ethics-related studies and activities were advanced, and the World Commission on the Ethics of Scientific Knowledge and Technology (COMEST) published a report in 2003 entitled *The Teaching of Ethics*.[37] The Report stresses the significance of teaching ethics by stating that "[t]he study of ethics is important not only for our individual lives, but also for developing the insight and competence we as a community need in order to face the challenges of the present and the future in a reasonably successful way."[38] Furthermore, the Report summarizes the reasons for the increasing interest in ethics. According to the Report, rapid changes, rising contact among different cultures, developments in the Internet and media, deteriorations in traditions, advances in science and technology, increasing environmental concerns, and improvements in gene technology have raised the importance of teaching ethics.[39]

The necessity of ethics education or teaching ethics (as interchangeable phrases) has been recognized at the United Nations' level since the 1990s. Nevertheless, this recognition does not resolve all challenges by itself. For example, in a nutshell, ethics education may be regarded as the teaching or learning of moral values, rules, and principles. However, one of the questions is whether it is sufficient to transfer knowledge of ethics for instilling ethical conduct. Gordijn and ten Have query this issue by comparing Socrates and Aristotle's views on the relationship between the acquisition of knowledge and the demonstration of ethical behavior. Gordijn and ten Have interpret Aristotle's stance as being more realistic than Socrates' stance; the former does not consider knowledge an adequate factor for displaying virtuous conduct, while the latter

assumes the presence of knowledge sufficient for exhibiting ethical behavior. Even though the authors admit that ethics education does not only consist of the possession of knowledge and find it doubtful that there is a direct link between teaching ethics and moral acts, they take the position in favor of teaching ethics.[40]

Michael Wright reviews the literature to determine whether there is a link between ethics education and ethical behavior. Wright is a proponent of supporting the idea that "education is the best means of developing good ethical behaviour," but the review does not give enough evidence to prove that ethics education explicitly improves moral conduct.[41] Another literature review conducted by Cannaerts, Gastmans and Dierckx de Casterlé gauges nursing students and educators' viewpoints about the impact of ethics education on nursing students. The review indicates that students and educators believe that ethics education increases students' "ethical perceptive, reflective, and decision-making skills. However, they barely mention the contribution of ethics education to the development of ethical behavior in nursing practice."[42] The literature review reveals that teaching ethics creates certain improvements in students' ethical knowledge, sensitivity, and skills, but its contribution to virtuous conduct is not obvious enough.

Schwitzgebel and his colleagues observed the behavior of audiences during four meetings of the American Philosophical Association in 2008 and 2009 to examine the courtesy of the participants and decide whether the behavior of philosophers attending ethics sessions is morally better than the behavior of philosophers attending non-ethics sessions. The hypothesis was that "professional ethicists would behave morally better than do socially comparable non-ethicists," and it was tested by assessing the behavior of the participants by observing whether or not they talk loudly during the sessions, let the

door slam when entering or leaving the sessions, and leave trash and cups behind at the end of the sessions.[43] However, the results of the three measures did not demonstrate a significant difference between the courtesy of ethics philosophers and non-ethics philosophers. In other words, the hypothesis that engagement in ethics would improve moral behavior was not supported by the results.[44]

This situation may be illuminated by three suppositions. First, as the aforementioned studies show, ethics education does not directly develop ethical behavior. Second, a correlation between teaching ethics and virtuous conduct may exist, but shortages or shortcomings of ethics education preclude the emergence of possible positive consequences. Third, there are methodological defects in the research looking to prove the influence of teaching ethics on moral behavior. However, instead of choosing one of these options, maybe some other questions should be asked, such as "Should ethics education change individuals' character or behavior?," "Is it an ethical and realistic expectation to desire to change one's character, especially in adult education?," or "Does the teaching of ethics differ from the teaching of other subjects?," and so on.

In terms of the method of teaching ethics, Bayard L. Catron underlines a close relationship between ethics and conduct and claims that the teaching of ethics is not different from the teaching of other subjects. Catron looks at teaching ethics as conveying the knowledge of ethics and likens the role of ethics professors to retailers selling knowledge.[45] In *The Vocation Lectures*, Max Weber explains young American students' attitudes by their tendency to equate a teacher's effort to a greengrocer's work: the former sells knowledge, while the latter sells cabbage, and points out the students' expectation that teachers be leaders in their fields.[46] Nevertheless, Weber calls to his students, saying:

> Fellow students! You come to our lectures with the expectation that we will be leaders, but you do not say to yourselves beforehand that out of one hundred professors, at least ninety-nine … neither claim, nor have any right to claim, to be "leaders" of any kind in matters of conduct.[47]

From this perspective, if a professor in management is not expected to be an outstanding leader, if a professor in economics is not expected to be a successful CEO, or if a professor in political science is not expected to be an inspiring politician, why is a professor in ethics supposed to be a role model of virtuous behavior? Moreover, why is the teaching of ethics considered more complex than the teaching of other subjects? In light of Weber and Catron's approach, an ethicist or a professor in ethics is merely a person selling his/her knowledge, like other professors in other academic disciplines.

It is an ideal situation to expect behavioral changes or influences from education. However, expertise in knowledge does not bring about expertise in practice per se. For example, an exceptional soccer player is not necessarily an excellent soccer coach, and vice versa, because not every person can successfully transfer knowledge into practice. This circumstance is valid for all academic areas including teaching ethics. As the research carried out by Schwitzgebel and his colleagues shows, if ethics education does not engender a remarkable difference in ethics professors' moral conduct, how realistic would it be to expect changes in the ethical behavior of students/individuals with limited knowledge of ethics? Of course, teaching ethics may create perfect role models of virtuous conduct, but lack of this should not be regarded as the failure of ethics education. The expectation of changes in ethical behavior points out the desire for character education which is a traditional approach in moral education.[48]

4.3.2 Some Approaches to Ethics Education

The issue of whether education should instill a particular moral character is one of the essential subjects of ethics education. The response to this circumstance is directly related to the apprehension of the role of teaching ethics. UNESCO's COMEST Report delineates the study of ethics' aim as follows:

> - the study should increase the students' awareness of ethical issues
> - provide a deep understanding of ethical matters and greater clarity in ethical questions
> - place ethical problems in a wider context and make explicit the alternatives that we may choose from, and how their various positive and negative consequences are experienced by those who are affected
> - develop the skill for ethical analysis and argumentation
> - determine areas where social practice or legislation is at odds with ethical standpoints which seem to be well-founded.[49]

Therefore, even though the Report puts attention to the improvements in ethical awareness, the insight of ethical issues, and the judgment of ethical problems, it does not mention the necessity of any character changes.

Darcia Narvaez touches on two major approaches in ethics education, traditional character education and rational moral education, and suggests a third approach, integrative ethical education, for shaping the moral development of children.[50] Undoubtedly, ethics education is not solely the matter of childhood moral development, and in terms of character formation, childhood education differs from adult education; for example, disciplining children to behave in a determined way is much easier than instructing adults to act in a particular manner.[51] Nevertheless, the theories and approaches in this specific area may be utilized in order to draw up a general structure for all kinds of ethics teaching. According to Lapsley and Narvaez, the moral formation of

children is a classic objective of formal education.[52] However, children's first educational institutions are their families and first teachers are their parents, who inculcate in the children certain moral values.[53] Therefore, not just formal education, but also informal education aims to contribute to childhood moral development. Nonetheless, traditional character education does not represent a liberal moral formation of individuals; it denotes the transmission of packaged moral norms, which may come from the family, school, church, or state's moral acceptances, and the compliance with these norms.[54]

The second approach Narvaez mentions is rational moral education, also known as the cognitive-developmental approach, which "seeks to facilitate the development of autonomous moral judgment and the ability to resolve disputes and reach consensus according to canons of fairness."[55] Traditional character education tries to instill in individuals a particular morality, whereas rational moral education strives to teach individuals how to establish good moral character without imposing a specific morality. The former limits the learner to a ready-made moral system, but the latter empowers the learner to discover all moral systems and build his/her own moral character. For this reason, in traditional character education, the educator aims to directly shape the learner's moral acceptances, while in rational moral education, the educator only helps the learner to improve his/her moral judgment. Traditional character education might be criticized due to its authoritarian aspects, and rational moral education could be denounced because of not containing certain moral perspectives.[56]

Another approach concerning teaching ethics is ethical acculturation, proposed by Handelsman, Gottlieb, and Knapp. They adapt John W. Berry's acculturation concept to ethics training. Handelsman and his colleagues liken the process of the ethics learning of

psychologists to the reactions of a person who encounters a new culture.[57] Berry states that in multicultural societies, the members and groups of dominant as well as non-dominant cultures must pay attention to cross-cultural understandings and influences. According to Berry, when individuals and groups from distinct cultures meet, in light of cultural maintenance as well as contact and participation, one of the four possibilities of acculturation occurs: assimilation, separation, integration, or marginalization. *Cultural maintenance* shows the insistence on the continuation of the existing culture, and *contact and participation* exhibits the interaction among culturally dissimilar individuals and groups. Assimilation and separation indicate the attitude of individuals and groups who encounter other cultures regarding whether to maintain their own cultures and interact with the individuals and groups from other cultures. Exhibiting low cultural maintenance and desiring a high level of interaction with others demonstrate *assimilation*, while high cultural maintenance and little or no interaction with others refer to *separation*. On the other hand, integration and marginalization reveal the level of unification of cultures and interest in having a relationship with others. *Integration* implies a balance between maintaining the existing culture and internalizing the new culture, as well as a strong interest in communicating with others, whereas *marginalization* points to little or no cultural maintenance as well as little or no relationship with individuals and groups from other cultures.[58]

The ethical acculturation model focuses on the process of ethics training of graduate students in psychology who have already learned some professional behavior and values. Furthermore, this model considers ethics training a complicated issue more than merely teaching or learning ethical norms. Handelsman, Gottlieb, and Knapp equate

the existing ethics knowledge of graduate students, who desire to become psychologists, with the culture of individuals who enter a new culture. This approach asserts that similar to the need of the cultural acculturation of individuals encountering new cultures, psychologist candidates must experience the process of ethical acculturation to develop their ethical knowledge, behavior, and skills.[59] The issue of cultural maintenance, in cultural acculturation, denotes students' "preexisting notions of right and wrong professional behavior" in ethical acculturation, and the matter of contact and participation represents "the APA Ethical Standards and other indicators of psychology ethics."[60] In other words, maintenance refers to students' personal values and contact, and participation means professional ethics, norms, and standards.

Like cultural acculturation, ethical acculturation has four strategies emerging in accordance with the relationship between maintenance and contact. In ethical acculturation, integration is the most desired strategy and demonstrates students' strong tendency to maintain their preexisting values and strong interest in new professional standards, which "represents the most consistency or coherence between personal and professional identities and values."[61] Contrary to integration, marginalization which indicates a low level of interest in personal morality and professional values is the least popular strategy due to denoting the lack of personal as well as professional moral development.[62] The third strategy is assimilation, which represents students' indifference to their own moral values and high enthusiasm for professional identity. Under the presence of assimilation, individuals give up their own ethical standards and completely internalize professional rules. Handelsman and his colleagues regard this strategy as dangerous for students because of the possibility of causing "empty, legalistic, and overly

simplistic applications of our ethical principles."[63] The last strategy of ethical acculturation is separation, exhibiting a strong focus on personal moral acceptances with negligence in ethical principles and rules of the profession. This strategy may also lead to detrimental consequences due to not understanding the importance and necessity of applying professional standards.[64]

The ethical acculturation model acknowledges the strategy of integration as the ideal situation. Ethical acculturation aims to integrate individuals' preexisting personal and professional identities into new professional rules, principles, and values. The students' previous moral standards are respected, and the students are requested to be aware of their own personal, cultural, and professional backgrounds, but are also required to internalize the ethical codes, values, and principles of the profession they want to enter. Therefore, assimilation, separation, and marginalization are deemed problematic strategies; ethical acculturation is defined in the scope of the strategy of integration as an ongoing process, giving the student "an opportunity to identify and clarify their personal, cultural, and family of origin values and to consider how these will align with the new or changing professional culture."[65] In this sense, the ethical acculturation model accepts ethics education not only as the teaching or learning of a list of ethical codes and rules, but also as "a process of developing and maintaining a professional identity" through integrating the participants' previous individual cultures and experiences into the professional moral requirements.[66]

However, the transition from the preexisting culture to the new one may be more difficult than expected. Gottlieb and his colleagues draw attention to this issue. They state that in the event of there being too much of a gap between personal and professional

cultures, some students might implement the strategy of assimilation to be able to accommodate themselves to the new professional qualifications.[67] Nevertheless, remarkable conflicts between the students' previous moral systems and the new professional culture could cause the appearance of separation and marginalization strategies as well. Assimilation indicates a reaction welcoming the new professional identity. However, the reaction deriving from the cultural conflict may manifest itself as a rejection of this new identity, so separation and marginalization are also likely possibilities in the case of a high inconsistency between previous and new conditions. For such "cultural distance"-based challenges, Gottlieb and his colleagues suggest an early detection of the problem and its magnitude as well as the students' eagerness and capability to adopt integration.[68]

According to Bashe et al., the ethical acculturation model has four benefits. First, this model emphasizes the significance of ethics in professional identity and the essentiality of refurbishing ethics knowledge. Second, ethical acculturation does not impose an assimilating strategy; on the contrary, it recognizes the worthiness of personal experiences and values. Third, ethical acculturation is regarded as an ongoing process, hence individuals remain active in the integration of their personal virtues and professional standards. Fourth, this model represents a journey, which starts by identifying personal values and professional needs and ends by integrating personal and professional identities. Therefore, ethical acculturation provides a progressive development for ethics education.[69]

In the case of comparing the ethical acculturation model with the character education approaches (traditional character education and rational moral education),

some advantages and disadvantages of each can be mentioned. However, one of the main differences between the ethical acculturation model and character education approaches is the distinction between their primary groups; the ethical acculturation model is established on the idea of acculturating graduate students who choose to be a psychologist, whereas the character education approaches focus on the moral development of children. The former tries to increase ethical knowledge and skills of already educated adults in light of professional requirements, while the latter strives to discover the most appropriate way to form or shape the character of children according to moral values.[70] From this perspective, in terms of the target groups, the ethical acculturation model seems to suit ethics education in healthcare more than character education approaches. Furthermore, the essential feature of ethical acculturation, which requires integrating personal values into professional identity, is a superiority of this method. The combination of respecting the differences in individuals' cultural backgrounds and experiences and recognizing the necessity of professional moral standards is crucial in teaching ethics in professions. On the other hand, the liberal aspect of rational moral education, which "is concerned with the development of reasoning and autonomy," also increases the attractiveness of proposing/forming a new model for ethics education in healthcare.[71]

4.4 The Goals of Ethics Education

In the first sections, the concepts of ethics, education, and ethics education were explained to clarify what these terms imply. Furthermore, in the second section, two major approaches in education, traditional character education and rational moral education, as well as the ethical acculturation model suggested by Handelsman and his

colleagues, were succinctly expounded. In this section, some important issues will be highlighted in light of the acquired ideas from the earlier sections, and then the goals of ethics education in healthcare will be proposed.

4.4.1 How to Understand Ethics Education

Prior to delineating the goals of ethics education, it would be beneficial to underline some points in light of the matters mentioned in the above sections. First, ethics education is a very broad concept pertinent to all academic disciplines. Even though it may be possible to outline certain objectives of teaching ethics available for more than one academic area, due to some unique characteristics and requirements of each field, focusing on a specific discipline would give the opportunity to address more definite goals. For this reason, in this chapter, ethics education refers to the teaching of ethics in healthcare which can also be referred to as bioethics education. Henk ten Have defines bioethics as "the discipline that is focusing on ethical issues in medicine, health care, and associated technologies."[72] Indeed, though bioethics may be evaluated as conceptually more comprehensive than healthcare ethics, in the scope of the present chapter, the terms *ethics education in healthcare* and *bioethics education* are regarded as interchangeable.

Second, the term 'healthcare' covers many professionals including physicians, nurses, pharmacists, therapists, psychologists, and so on. In this view, healthcare ethics/bioethics does not denote a particular profession, but all healthcare professions. "Professional ethics relates to the values and standards of a particular profession, which are generally made explicit in professional codes of conduct or practice."[73] Therefore, bioethics does not directly imply the professional ethics of a specific profession; it

encompasses the professional ethics of all healthcare professions. Additionally, bioethics education indicates the teaching of ethics to someone who decides to enter a profession in healthcare, has a certain level of education, and carries particular moral values. For this reason, it is important to note that the target group of bioethics education is adults with at least high school education.

Third, ethics education is an ongoing process improving the learner's ethical knowledge and skills as well as enhancing the learner's ethical cognitive development regarding the acquired knowledge and skills. In this view, ethics education aims to stimulate some changes in learners' ethical knowledge, perception, and perspective. However, it is not an assimilation process. Cultural assimilation means to abandon the preexisting cultural identity, and ethical assimilation implies to leave the previous morality.[74] Ethics education should be understood as the integration of preexisting moral values with new professional ethics standards. The research study conducted by Rodríguez et al., which contains a survey of 136 ethics instructors from the American Psychological Association (APA) accredited programs in the United States and Canada, demonstrates that more than 86 percent of the educators specify the aims of ethics education as 'advancing critical thinking', 'preparing students to use ethical decision making models', 'providing specific information and resources on ethics', and 'teaching the ability to make difficult decisions.'[75] From this perspective, ethics education should not impose a specific morality on learners; it should teach the relevant ethical theories, norms, and principles to learn how to think critically and make ethical assessments and autonomous decisions.[76] For example, when considering beginning of life issues, bioethics education should not impose any pro-life or pro-choice argument on anyone. It

should teach all aspects of the arguments, pertinent moral theories, and ethical principles as well as appropriate methods for making morally acceptable judgments in accordance with cultural, religious, and philosophical backgrounds.

Fourth, bioethics education is not traditional character education. Traditional character education is a widespread, but also contentious approach, which aims to mold children's moral personality.[77] "For traditional character education, morality is ready-made and good character requires submission to its preexisting norms."[78] On the other hand, bioethics education intends to increase healthcare professionals' knowledge and skills to identify ethical issues and make ethical judgments.[79] Therefore, while traditional character education focuses on children's moral development, bioethics education concentrates on the teaching of ethics to healthcare professionals. Moreover, the former imposes a particular morality and requests obedience, while the latter tries to enhance ethical awareness and moral reasoning. In this view, it is believed that bioethics education does not have a function to form a new character. The improvement of ethical knowledge and skills may influence the individuals' personal behaviors in a positive manner. However, the effectiveness of ethics education should not be measured by non-profession-related behaviors or activities; it should be gauged by the adaptation to professional moral requirements as well as by the ability to utilize ethical awareness, ethical analysis, and moral judgment in professional implementations.

Finally, bioethics education may be formulated in the scope of the rational moral education approach and the integration strategy of the acculturation model. Even though rational moral education is related to the moral development of children, its neutral aspect (aiming to teach morality in an impartial manner) and its indirect feature (considering

educators solely as the facilitators of moral development) may be applicable to bioethics education to create a liberal and humanistic teaching environment.[80] Moreover, the perspective of the integration strategy of ethical acculturation produces a useful approach to emphasize the significance of the consolidation of personal moral values and professional ethics qualifications.[81] Furthermore, the view of recognizing and respecting individual moral differences and diverse experiences could facilitate the development of global bioethics, which focuses on "the ethical concerns of humanity" worldwide and "contains "the ethical values and principles of various populations without assuming that one specific set of values and principles is dominant."[82] In this context, bioethics education is not limited to any particular moral systems; rather, it encompasses the teaching of all moral aspects and promotes the improvement of ethical awareness, thinking, and judgment through the integration of personal and professional moral acceptances.

4.4.2 The Goals of Ethics Education

Outlining the goals of ethics education is crucial in order to accurately describe its concept and determine its scope. Because of this reason, many studies examining ethics education address certain goals. For instance, Li-Ling Hsu points out the purpose of ethics education in nursing as producing "morally accountable nurses."[83] Similarly, Sudhir K. Chawla and his colleagues identify the aim of ethics education in accounting as producing "ethical professionals."[84] Moreover, Henk ten Have accentuates the consensus on the eventual objective of ethics education in bioethics as producing "good health professionals and scientists."[85] These statements prove that the ultimate goal of ethics education may be summarized as producing good or ethical professionals. However, this

concise phrase carries a subjective remark and needs to be detailed in order to elaborate which specific components engender ethical professionals.

According to Cubie L . L. Lau, the aim of ethics education in business is "to help students to be more aware and sensitive to the ethical consequences of their actions."[86] Sanders and Hoffman express the main goals of ethics education in social work as improving moral judgment, which indicates how to deal with ethical conflicts, and moral sensitivity, which demonstrates the ability to pinpoint ethical issues.[87] Mihyun Park et al. regard the objective of ethics education in nursing as "to develop among students the necessary skills for ethical decision making: moral sensitivity and moral reasoning."[88] Kathryn E. Wilt elucidates the goals of ethics education in medicine and nursing as (1) "to promote the development of the virtues and values inherent to the professions of medicine and nursing"; (2) "to affect attitude formation"; (3) "to increase understanding of ethical theory"; (4) "to promote identification of ethical problems;" and (5) "to improve ethical analysis and decision making."[89] Even though each of the aforementioned studies evaluates teaching ethics in a different discipline or profession, they mostly agree on improving ethical awareness, sensitivity, and judgment to identify, analyze, and resolve ethical issues and conflicts.

In respect to bioethics education, the report of the Hastings Center, *The Teaching of Bioethics,* and Daniel Callahan's article, *Goals in the Teaching of Ethics*, are two pioneer works to specify the goals of bioethics education.[90] The Hastings Center's report of 1976 introduces four goals: "identifying and defining moral issues"; "developing strategies and analyzing moral problems"; "relating moral principles to specific issues and cases"; and "training a group for careers in bioethics," whereas Daniel Callahan

addresses: “stimulating the moral imagination”; “recognizing ethical issues”; “eliciting a sense of moral obligation”; “developing analytical skills”; and “tolerating—and reducing—disagreement and ambiguity” as the goals of ethics teaching.[91] Both of these studies provide a compelling insight into bioethics education and its goals. However, the fascinating growth in bioethics and bioethics education in the last few decades requires revisiting these goals in accordance with current developments, needs, and challenges.

For this reason, in this chapter, the goals of ethics education will be elaborated in light of the four pillars of the Delors Report. In other words, the four pillars of the lifelong education approach will be adapted to align with the goals of ethics education. The concept of lifelong education, which is also referred to as “learning throughout life,” was counted as a guiding principle requiring individuals to “be in a position to keep learning throughout [their] life” by UNESCO’s Faure Commission Report.[92] The Delors Report re-evaluated and broadened the concept of lifelong education in order to deal with rapid changes and advances as well as new situations.[93] The concept of lifelong education is parallel to the perspective of ethical acculturation which deems ethics learning as an ongoing process. Moreover, there is a similarity between the reasons behind the concept of lifelong education and the arguments counting ethical acculturation as an ongoing process. The ethical acculturation model requires individuals to keep continuing their ethical training throughout their professional lives due to the ongoing changes.[94] Therefore, the precondition of adapting the pillars of the concept of learning throughout life to ethics education is to acknowledge teaching ethics as an ongoing process throughout learners’ professional lives. For overcoming the continuous changes in healthcare and healthcare-related areas, healthcare professionals should proceed with

their ethics education as long as they practice their professions. In this view, the goals of ethics education are regarded as follows:

- to increase ethical knowledge (learning to know),

- to improve ethical skills to strengthen ethical sensitivity, awareness, and judgment (learning to do),

- to develop ethical behavior (learning to be),

- to promote cultural competence (learning to live together).

4.4.2.1 Increasing Ethical Knowledge as Learning to Know

The acquisition of knowledge is not only the first goal of ethics education, but also the initial objective of all kinds of education. Some approaches may attribute further qualities to education, but there is a consensus among them that the primary function of education is to gain knowledge.[95] This criterion is also valid for ethics education. For instance, Campbell, Chin, and Voo explain the goals, assessment methods, and outcomes of medical ethics education through a three-level ascending pyramid, the first level of which is knowledge.[96] Similarly, Sudhir K. Chawla et al. define the initial goal of an ethics course as to "[d]eliver a common body of knowledge in ethics."[97] Furthermore, Henk ten Have underscores the weight of knowledge in the understanding of ethical issues.[98]

This goal of ethics education refers to the possession and increase of the information about ethics-related subjects. Learning ethical theories, rules, principles, codes, and other applicable ethical information are related to this objective. Ethics education has the task of identifying, analyzing, and resolving ethical issues and

conflicts. Having adequate ethics knowledge is the necessary, but insufficient, condition of fulfilling this task. For this reason, ethics education must provide satisfactory ethics information to be able to establish or improve other pertinent considerations, such as developing ethical skills. From this perspective, in terms of adapting the concept of learning throughout life to ethics education, "improving ethical knowledge" matches "learning to know," which requires "combining a sufficiently broad general knowledge with the opportunity to work in depth on a small number of subjects. This also means learning to learn, so as to benefit from the opportunities education provides throughout life."[99] In this sense, ethics education should aim to supply adequate information to know relevant subjects and concepts.

4.4.2.2 Improving Ethical Skills to Strengthen Ethical Sensitivity, Awareness, and Judgment as Learning to Do

As mentioned above, acquiring or increasing ethical knowledge is the first step in ethics education. However, the presence of knowledge is not sufficient per se to identify, analyze, and resolve ethical matters and challenges. The ability to stimulate knowledge and transform it into actions is also certainly important and necessary. Henk ten Have gives an example to clarify the relationship between knowledge and skills and says that "if the focus is on informed consent, students should know what it is; they should have information and facts about this concept, but they should also learn how to apply it in practice."[100] Therefore, besides ethical knowledge, ethics education should provide the opportunity to improve ethics-related skills: ethical sensitivity, ethical awareness, and ethical judgment. Catherine Robichaux states that in the event of creating a learning-friendly environment, ethical skills can be taught through ethics education.[101] In this

context, many authors, such as Jensen and Greenfield, as well as Mihyun Park et al., recognize the development of skills as an essential purpose of ethics education.[102]

The aim of strengthening ethical skills is to gain or increase the ability to learn to do a job, as highlighted by the concept of learning throughout life. Ethics education should enhance healthcare professionals' skills to improve their ethical sensitivity, awareness, and judgment. Developing the pertinent skills is significant not only to meet the needs of the daily routines of the professions, but also to deal with unexpected ethical circumstances.[103] Additionally, the acquisition or improvement of skills needs long-term training, hence the teaching of ethics should be accepted as a process, in terms of strengthening skills as well.

4.4.2.3 Improving Ethical Behavior as Learning to Be

As previously elaborated, ethics education does not refer to traditional character education. Therefore, in principle, teaching ethics does not necessitate forming virtuous character or behavior. Moreover, according to several studies, it is questionable whether ethics education creates moral behavior.[104] However, at this point, the idea of generating a virtuous character should be differentiated from the view of influencing professional behavior. For instance, constantly instilling in a child the principle of not lying in life because of its negative consequences may be considered character formation, whereas making sure a healthcare professional does not lie in their relationship with patients due to the patients' rights to accurate informed consent could be regarded as professional behavior improvement. In this view, the goal of improving ethical behavior implies promoting professional moral behavior rather than one's general character. Of course, helping to create more appropriate behaviors in one's life may be desirable, but it should

not be counted as one of the objectives of ethics education in healthcare because of the professional aspect of bioethics.

Furthermore, improving ethical behavior is formulated in light of the third pillar of the concept of learning throughout life as learning to be. Learning to be suggests improving one's personality and discovering his/her potential, like "memory, reasoning, aesthetic sense, physical capacities and communication skills."[105] In the case of the adaptation of this approach to bioethics education, it can be emphasized that the development of professional ethical behavior should be fulfilled not only by improving ethical knowledge and skills, but also by exploring and promoting individual potential.

4.4.2.4 Promoting Cultural Competence as Learning to Live Together

Cultural competence implies beliefs, attitudes, behaviors, and policies facilitating a compatible togetherness in a cross-cultural environment.[106] According to Gregory Juckett, cultural competence refers to "possessing knowledge, awareness, and respect for other cultures" and requires recognizing cultural differences and respecting their own characteristics.[107] Cultural, religious, and social diversity in healthcare, as well as in all levels of multicultural societies, necessitates finding a peaceful way to prevent cultural assimilation as well as cultural separation or marginalization. In this view, the integration strategy of ethical acculturation provides an outstanding method to encourage the survival of moral differences in an integrated structure.[108] This facet of ethics education should be strengthened by the perspective of "learning to live together." The Delors Report states that learning to live together

> by developing an understanding of others and their history, traditions and spiritual values and, on this basis, creating a new spirit which, guided by recognition of our

> growing interdependence and a common analysis of the risks and challenges of the future, would induce people to implement common projects or to manage the inevitable conflicts in an intelligent and peaceful way. Utopia, some might think, but it is a necessary Utopia, indeed a vital one if we are to escape from a dangerous cycle sustained by cynicism or by resignation.[109]

Regardless of being a utopia or not, the underscored understanding should be reflected in ethics education in order to transcend the teaching or learning of a list of ethical codes, rules, and principles. For this reason, it is most certainly believed that promoting cultural competence is a primary goal of ethics education.

In regard to the perspective of this chapter, promoting cultural competence is the most striking goal. In particular, increasing ethical knowledge and improving ethical skills to strengthen ethical sensitivity, awareness, and judgment are classic goals of ethics education emphasized by almost all studies which inquire into the aims of teaching ethics. However, the cultural, religious, and social diversity bolstering a cultural competence-based approach is the unique characteristic of the present study. As an idea as well as an ideal, endorsing diversity is not a new view, but recognizing the importance of diversity as a central goal is an original approach of this chapter. From this perspective, in the following section, the difficulty of reconciling distinct cultural and religious values and positions as well as the necessity of enhancing cultural competence through ethics education will be elaborated.

4.5 The Importance of Promoting Cultural Competence

Cultural competence is an all-inclusive perspective that requires being cognizant of cultural differences, respecting distinct characteristics, and creating a reconcilable cross-cultural environment. Religions and cultural customs, features, and perspectives are

the main elements shaping individual and social behaviors, attitudes, and policies. The ability to manage religious and cultural pluralism requires a high awareness and meticulous effort. However, in many cases, individuals or groups intend to implement "their own cultures, religious traditions and unique moral systems," which may cause insurmountable conflicts and problems.[110] Being able to compromise distinct ethical views might sometimes appear almost impossible, such as in the event of abortion and euthanasia. Even though such challenges may make the position of bioethics in the multicultural world questionable, bioethicists should strive to find an answer concerning whether it is feasible to create a common ethical ground or forge a global bioethical stance. In this sense, ethics education should help to create a common ground to reconcile ethical issues in today's multicultural societies.

4.5.1 Religious and Cultural Pluralism

Religions have a remarkable impact on discussions and judgments in ethics. They generate a definite control and authority about particular cases on their followers. Veatch states that religions consider themselves possessing "mechanisms of knowing divine truth or divine will."[111] For a follower of a religion, the *divine truth* refers to absolute knowledge to which one is to submit. In this sense, a physician, person, or institution that observes a religion's practices is supposed to exhibit a certain standpoint toward these religious discourses. For example, there are some medical procedures that Roman Catholic healthcare organizations do not carry out, such as abortion, direct sterilization, and heterologous fertilization. These medical practices are deemed morally wrong and prohibited by the Church. Thus, this religious standing is an essential part of Catholic healthcare institutions. Catholic healthcare organizations' employees, patients, and

partnerships are expected to respect and uphold the organizations' ethical and religious directives.[112]

Therefore, religious norms and provisions are essential sources of ethics for religious individuals, physicians, and ethicists. However, secular individuals, physicians, and bioethicists may not be inclined to attribute any value to these norms.[113] In many cases, biases, prejudices, and stereotypes against a particular faith prevent some people, even philosophers, from making fair and impartial judgments about the faith's teachings and ethical codes. Daniel Callahan says that "one of my toughest problems during the Hastings Center's first twenty years was persuading the philosophers to sit down with the theologians and to take them seriously. The secular philosophers could not give a damn for what the theologians were saying."[114] Callahan witnessed this situation about 30 years ago and many things have changed throughout this period. Nonetheless, it may not be easy to claim that such biases have been entirely eliminated. Many people and groups may still tend to repudiate any religious ground for moral norms.[115]

Even though religious and secular medical ethics occasionally indicate similar moral norms and values, their ethical views mostly do not coincide because they differ from each other due to their sources. Furthermore, it is possible to see major ethical differences among faiths, even among the sects of a religion. Additionally, the followers of a faith might interpret a religious norm in various ways. Therefore, it is possible to encounter various moral judgments among followers of a religion because of individual or sectarian differences. However, despite the aforementioned variations, religions strive to generate a common ground in ethics by imposing specific directives on their believers. For instance, the Catholic Church's ethical and religious directives, birth control and

euthanasia-related statements, and similar declarations aim to create guidelines for all its followers and institutions.[116] Moreover, despite the past challenges in the recognition of religious contributions to ethics, as a result of the effort made by religious groups, religious influences on bioethics and law have recently become increasingly apparent, especially in the United States.[117]

However, Andrew Fagan perceives the position of some religions and cultures as highly risky to bioethical norms, values, and principles. He claims that "the character of some people's relationship with their cultural or religious community significantly constrains the possibilities for acting autonomously."[118] According to Fagan's autonomy-based evaluation, in societies excessively dominated by religious or cultural rules, persons cannot make autonomous decisions under the pressure of their religion or culture. Furthermore, Fagan is concerned about the influence of such religions or cultures on multicultural societies to impact/shape public services over time.[119]

Max Charlesworth underlines another opposing argument about religious-oriented ethical views. He sees a liberal structure that implicitly indicates secular courses of action as the precondition of an ethically pluralist society. He argues that in a pluralist society, a social consensus cannot be established due to the presence of religious practices which carry essential biases and prevent reaching an agreement on certain ethical issues.[120] For instance, the Catholic Church's stance on abortion, sterilization, euthanasia, assisted suicide, and embryo experimentation is unwavering. Charlesworth points out the current difference between the Catholic standpoint and the feminist ethical position on beginning of life matters to demonstrate why a consensus is very difficult or

impossible. The Church believes in the sacredness of human life, while the feminist ethical position respects women's choice.[121]

However, contrary to the arguments that certain religions or cultures pose a threat to bioethical principles, some scholars assert that religious individuals, groups, and institutions are under a great deal of pressure from secular tensions. The pressure does not merely come from external sources, such as the activities of the proponents of abortion or euthanasia, but also stems from internal sources. Despite religious healthcare institutions officially upholding religious perspectives on certain medical procedures, their employees may have a distinct position on the same issues. Therefore, such conflicts are internal tensions on religious healthcare institutions' practices. Additionally, it is anticipated that the pressure on these organizations will increase because their ethical responses to changes and cross-cultural problems cannot compete with the pace of medical and technological developments.[122]

Culture is a broad concept defined in various ways by social scientists. In a general framework, culture might be described as norms and values acquired from the social environment.[123] Each society tries to pass its unique characteristics on to individuals living in the society. Moreover, individuals more or less reflect their society's language, beliefs, values, attitudes, and behaviors. In this context, despite the various definitions of cultural pluralism available in sociological and political literature, in this chapter cultural pluralism refers to distinct cultural features of people living in multicultural societies.[124]

In terms of Beauchamp and Childress' four ethical principles, the effects of cultural differences on ethical issues largely appear in the comprehension and application

of the principles of respect for autonomy and justice. For example, informed consent and advance directive-related matters demonstrate substantial differences among cultures. The principle of respect for autonomy has a dominant influence in Western culture, and the requirements of this principle are met by providing correct and thorough information to patients. In Western culture, regardless of the content of information, including either good news or bad news, physicians are expected to inform patients to give them the opportunity to make their own autonomous decisions about their own treatment processes and procedures. However, many research studies show that many other communities refuse the disclosure of information to patients with serious illnesses when the news is bad, on the grounds of protecting the patient from psychological harm. Similarly, giving advance directives or making any end-of-life decisions could be considered inappropriate to their cultural norms.[125]

In general, Western culture and bioethics are described as individualistic and autonomy-oriented, while non-Western cultures are defined as familial and paternalism-oriented. Nevertheless, according to Leigh Turner, some studies attribute an excessive emphasis to Western bioethics' autonomy-oriented characteristics. As a generalization, it can be acknowledged that Western bioethics (the term *Western bioethics* usually refers to American, Canadian, and British bioethics) and law ascribe a specific worth to individual autonomy. However, research studies indicate that not sharing bad news with patients and the role of family members in terminal diseases are both found worldwide. Even in Canada and the United States several people and communities do not support the disclosure of end-of-life information to patients. Nonetheless, it is rather difficult to reach

a consensus among different cultures on certain ethical issues, such as informed consent, advance directives, and surrogate decisions.[126]

Cultural differences are not only about the principle of respect for autonomy, but are also related to the implementation of the principle of justice, which differs from one culture to another. On that point, an example is disclosed by Sirkku K. Hellsten, an international aid to the Karamoja region in Uganda, about supplying food to the people struggling with starvation. During the distribution of the food, on the basis of Western values, the aid team had given priority to the children and pregnant women. However, it was later realized that the food given to the children and pregnant women had been served to the elders due to the local social values giving ultimate respect to the elders.[127] This example demonstrates that essential and unanimous values of a particular culture can diverge from the values of another culture. As the example clearly shows, children and pregnant women might have priority due to their vulnerability in Western culture, but another culture might assign priority to the elders because of its social norms.

Therefore, as is the case with religious differences, people, groups, and communities with distinct cultural traits interpret and implement ethical principles and norms differently. One view recognizes the disclosure of bad news as a requirement of autonomy, whereas another perspective refuses it on the grounds of protecting the patient from psychological harm. This and similar ethical cases may bring about irreconcilable conflicts, but it is also possible to encounter more serious matters, such as female circumcision. At such a point, the issue of whether to respect cultural differences and practices becomes very controversial.[128] In such cases, honoring differences might breach particular basic human rights. On the other hand, limiting the respectable area of the

differences could generate some other challenges. For example, imposing certain moral values, norms, and principles on another culture may be perceived as cultural imperialism by some views which emphasize the application of each culture's distinct characteristics.[129]

As a result, in light of the aforementioned framework, today's religious and cultural reality necessitates underlining the following points. First of all, it needs to be accepted that the modern world has a religiously and culturally diverse social structure. Second, not only does this diversity exist across the world, but also several countries contain many social, religious, and cultural differences within their own boundaries. Third, it seems impossible and immoral to unify or eliminate the existing diversity. Finally, a peaceful and plausible way must be discovered and applied to protect individuals and communities from external and internal pressures against their basic rights, while preserving their unique values and characteristics.

4.5.2 Seeking a Common Ethical Ground in a Pluralist Society

Morality is a set of several ideals, rights, rules, and principles that determine the social rightness and wrongness of human actions. Individuals start learning moral norms from their social and cultural environment from the day they are born. Some of the norms, virtues, and standards bind everyone, whereas some others are valid only for a particular group of people. Not killing, not harming, and not lying are examples of moral norms shared by all people with different cultures, religions, and moral values. However, certain specific norms are largely formed by professional standards, and religious or cultural traditions merely bind people together from these particular groups or

communities. For instance, medical norms and standards have to be taken into account primarily by health professionals – not every individual in a society.[130]

In this context, Beauchamp and Childress separate morality into two different subdivisions: common morality and particular morality. They claim that there are certain core norms, values, and principles whose acceptability does not depend on cultural, religious, or individual standpoints. For example, "not to lie, not to steal others' property, to keep promises, to respect the rights of others, and not to kill or cause harm to others" are basic tenets shared by all people.[131] Therefore, these moral norms, which are recognized and accepted universally, create common morality. On the other hand, particular morality refers to the moral norms and standards that are supposed to be applied only by specific persons, groups, or communities.[132] For instance, the Catholic Church's *Ethical and Religious Directives* contain mandatory provisions solely for Catholic healthcare institutions.[133]

John-Stewart Gordon suggests Beauchamp and Childress' approach distinguishing common morality and particular morality to prove the existence of certain universally valid moral norms to resolve bioethical challenges.[134] According to Gordon, the concept of common morality "offers a promising means of explaining and solving cross-cultural issues in ethics without denying the importance and legitimacy of cultural diversity."[135] Beauchamp and Childress count ten moral norms as some examples of the "rules of obligation", such as *do not kill*, *do not steal*, and *obey just laws,* as well as ten examples of virtues, like *honesty*, *fidelity*, and *kindness.*[136] According to Beauchamp and Childress, the moral norms, standards, and virtues they mention are: available in the common morality; shared universally; and produced from the history and experiences of

human beings. For this reason, the infringement of these moral norms is regarded as unethical and condemned by every person supporting and desiring a moral life.[137]

Though criticizing some points of Beauchamp and Childress' view concerning the common morality, Gert and his colleagues draw a similar common morality perspective, defending the presence of certain universal moral norms that are valid and operative everywhere in every culture, religion, and society.[138] However, Gert and his colleagues indicate two points about cultural and religious differences in healthcare ethics. First, according to them, there are not as many contentious issues as have been stated; many seemingly controversial matters do not obstruct people from making decisions. Second, they assert that many people, even physicians and philosophers find it more attractive to concentrate on irreconcilable ethical conflicts, even though such matters comprise only a small part of the whole. Additionally, instead of claiming to have an absolute potion for all moral problems in terms of their resolvability, they accept that it is possible both to provide an exact answer to certain moral challenges and be unable to offer exact answers to some other moral difficulties.[139]

Gert and his colleagues state that the common morality includes moral norms generating agreeable solutions to some moral problems. The purpose of the common morality is to prevent or reduce certain harms. The common morality does not have the ability to produce resolutions to every case and every person; it only exhibits a general structure for rational and impartial individuals to generate right answers to moral problems. In this context, they enumerate five rules and five ideals. The rules, such as *do not kill* and *do not cause pain*, indicate the harms, whereas the ideals, like *do not deceive* and *do not cheat*, demonstrate the ways to prevent the harms. Furthermore, this

formulation of the common morality shows the justifiable infringements of moral rules. For example, *do not cause pain* is a rule aiming to prevent harm. Immunization, however, may lead to a certain amount of pain, but the future benefits of the immunization override the rule.[140]

Beauchamp and Childress embody their ethical perspective with four principles, while Gert, Culver, and Clouser point out five rules and five ideals to clarify their ethical framework.[141] Even though there is a prolonged debate between the two parties on morality and its reflections, both sides believe that there are some moral norms that form the common morality.[142] These moral norms are shared, recognized, and applied universally to deal with moral challenges. Besides this similarity, another affinity between them is their approach toward the absoluteness of their principles or rules. According to Beauchamp and Childress, the principles, rules, and rights they mention are not absolute; they are just prima facie principles, rules, and rights that can be overridden under certain circumstances.[143] Similarly, Gert and his colleagues justify the violation of the rules they express under the conditions of impartiality, rationality, and knowability.[144] This last point in particular, indicating an agreement on the validity of the principles and rules, is very important in terms of their applicability to different norms of distinct cultures and religions. In comparison with absolutist approaches, these flexible standpoints are more likely to meet the differences of multicultural societies.

The idea of whether an ethical common ground can be generated is also studied by Robert M. Veatch. Veatch suggests a normative common morality approach named *convergence hypothesis*. According to Veatch, Hippocratic and professional ethics are not operative anymore. Therefore, there are two applicable ethical perspectives. The first one

encompasses religious aspects and indicates a collaboration of laypeople and health professionals who trust divine revelation-based moral structure. This model might be applied by religious groups or communities to form a religion-driven healthcare system. However, Veatch says that this cannot be implemented to the societies which possess moral values and norms not stemming from a particular faith. The second way is a model representing both religious and secular people who believe that the divine moral laws and secular moral norms can be explored through natural sources.[145]

In this context, Veatch proposes the *convergence hypothesis* containing a normative ethical framework that compounds moderate religious moral norms with modest secular moral norms. For this composition, Veatch explains two conditions. First, the converging religious and secular norms must be "knowable by natural means of reason and experience" instead of divine revelation; the moral norms must be derived from natural means rather than natural theology.[146] Furthermore, as the second condition, the moral norms must not claim absolute certainties due to the changes in the knowledge of morality and science. Veatch recommends humility in moral conclusions to accept the fallibility of the human being, even in the interpretation of religious moral issues.[147]

Additionally, for establishing the proposed cooperation, health professionals and laypeople coming from various religions, cultures, and professions should come together to build a consensus on ethical principles, rights, and rules. To substantiate his argument, Veatch gives the example of the *Universal Declaration on Bioethics and Human Rights* signed by the member states of the United Nations Educational, Scientific, and Cultural Organization (UNESCO) in 2005. According to Veatch, the declaration is a significant international attempt to create a universal ethical common ground.[148] "Rather than

reflecting the norms of the professional groups or national, religious or ideological bodies, the Universal Declaration can legitimately claim to speak for virtually all citizens of the world."[149]

Besides Robert M. Veatch, Leigh Turner also emphasizes the importance of international organizations' endeavors in terms of creating a global culture. According to Turner, even though it might be difficult to engender universal ethical norms, in order to increase the contribution of bioethics in formulating global norms and values, research studies and international health institutions need to pay more attention to the constitution of an international culture.[150] Moreover, as Veatch also states, instead of focusing on the empirical examples of ethical issues, concentrating more on the normative theories and aspects of ethics could be more helpful for constructing a common ground for cross-cultural ethical difficulties.[151]

4.6 Conclusion

In light of the basic principles of Kohlberg's cognitive-developmental approach (the rational moral education approach), Handelsman et al.'s ethical acculturation model, and the Delors Report's learning throughout life concept, the conceptual framework of ethics education and its goals were examined. These three perspectives were integrated to determine the notion of teaching ethics and its objectives. Rational moral education demonstrates the role of educators in teaching ethics which demands providing learners with all aspects, ideas, and approaches of ethics without imposing any specific one on the learners. Ethical acculturation represents the learners' position in ethics learning which requires the integration of the learners' preexisting moral values with new professional requirements. Learning throughout life denotes the precondition of ethics education as an

ongoing process. Under the general perspectives of these three approaches and the adaptation of the four pillars of the Delors Report to teaching ethics, the goals of ethics education were defined as: increasing ethical knowledge; improving ethical skills to strengthen ethical sensitivity, awareness, and judgment; developing ethical behavior; and promoting cultural competence. It is believed that assessing ethics education with the aforementioned objectives would give the opportunity not only to improve learners' ethical knowledge and skills to identify, analyze, and resolve ethical issues and conflicts through the development of their ethical sensitivity, awareness, and judgment, but also to discover and appreciate individuals' potentials, personal values, and peaceful ways to live together by enhancing cultural competence. In the case of culture and religion-oriented ethical disputes, as Gert and his colleagues mention, rather than exaggerating the differences, concentrating on common moral values and norms might help to create an ethical common ground in healthcare.[152] Furthermore, through cultural competence, embracing ethics education, supporting and enhancing universal agreements on common ethical issues, avoiding absolute positions on ethical views, and offering a normative perspective would alleviate many apparently irreconcilable ethical arguments.

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5 Chapter - Defining Quality in Bioethics Education[4]

5.1 Introduction

The United Nations Educational, Scientific and Cultural Organization's (UNESCO) Global Ethics Observatory (GEObs) database-2 demonstrates that as of November 2016, there are 229 ethics teaching institutions in the Europe and North America region.[1] This figure only refers to registered institutions, so the exact total of ethics teaching institutions is most likely much higher than 229 in the given region. For instance, the GEObs' database-2 shows only three teaching institutions in Turkey. However, GEObs' database-3, which illustrates the numbers of ethics teaching programs, displays 42 different ethics teaching programs from 11 different universities in Turkey.[2] Even these figures are far behind the definite number of ethics teaching programs in Turkey. Nonetheless, the GEObs' databases prove that many academic institutions across the world provide numerous programs to teach ethics. Despite the prevalence of the ethics programs, studies reveal that a consensus on the matter of how to teach ethics and what to teach has not yet been reached.[3] After the Universal Declaration on Bioethics and Human Rights (UDBHR) in 2005, UNESCO started to make an effort to introduce the UDBHR's principles through the production of bioethics core curriculum.[4] The curriculum and other relevant endeavors are significant contributions to ethics teaching in

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healthcare. Nevertheless, bioethics is an emerging and rapidly growing discipline which requires more studies to formulate certain common teaching models.

Additionally, in the case of evaluating quality in ethics teaching, the conceptual structure becomes more complex. The term quality is a sufficiently controversial subject in itself, and applying this concept to an unsettled bioethics education is like transforming a single-unknown equation into a multiple-unknown equation (in this chapter the terms bioethics and healthcare ethics are used interchangeably). The literature review done by Ercan Avci indicates that existing academic studies do not exhibit satisfactory evidence to determine the meaning of quality in ethics education.[5] Nevertheless, the plethora of literature regarding quality in other disciplines—including business, marketing, education, and healthcare—gives adequate indications to form a general framework to describe quality in ethics education. In this view, the aim of this chapter is to examine the notion of quality by inquiring into quality perception and implementation in some other academic fields to decide how quality in bioethics education can be defined. In this context, the chapter begins by elaborating on the concept of quality and expounding on why the matter of quality is important. It will continue by examining quality in two pertinent areas—education and healthcare—to understand their approaches to quality. The essay will conclude by suggesting a conceptual foundation for quality in bioethics education.

5.2 Definition of Quality

Quality is a popular term used by many disciplines. Even though quality carries a positive connotation, there is not an agreement in academia on the definition of quality; different sources underscore different characteristics of quality. The variety of definitions

does not indicate their inaccuracy, but shows the diversity of the expectations, needs, and requirements of areas to which quality is applied. For example, the quality of a good may differ considerably from the quality of a service due to the natural distinctions in their processes. Moreover, the priorities and requirements of a service, such as education, could diverge from the priorities and requirements of another service, like healthcare. Furthermore, in the case of the presence of several stakeholders, such as patients, care providers, and payers, each one's expectations might contradict the others' expectations. From this perspective, in this section, certain definitions and approaches, as well as the importance of studying quality, will be assessed to clarify the conceptual structure and obtain some clues for the matters evaluated in the next sections.

5.2.1 What Quality Means

The dictionary meaning of quality is "the degree of excellence of something."[6] This definition implies that while an action is performed, a good is produced, or a service is delivered, and the sense of excellence should be pursued to achieve quality. However, according to Geoffrey D. Doherty, explaining quality with excellence denotes nothing, except that quality is quality. Doherty likens quality to beauty in order to address the subjectivity of quality and considers excellence as subjective as beauty.[7] Philip B. Crosby emphasizes the distinction between the rhetoric concerning quality and the functioning of quality in reality by comparing quality with sex; people are eager for it and assume that they have the right instinct for knowing how to fulfill it, but this assumption does not prevent numerous divorces or separations.[8] Furthermore, W. Edwards Deming highlights the problem of expounding a concept with adjectives and says "[a]djectives like good, reliable, uniform, round, tired, safe, unsafe, unemployed have no communicable meaning

until they are expressed in operational terms of sampling, test, and criterion."[9] These statements, as well as many other sources studying quality unanimously, note the ambiguity and complexity of describing quality and the difficulties stemming from the features of the concept.[10] This situation represents the main agreement on quality; that quality is a contentious and multidimensional concept. The second consensus on quality is associated with its perception that different people grasp different aspects of quality in accordance with their focuses, needs, and expectations, which demonstrate the subjectivity of quality.[11]

However, despite the aforementioned challenges, the literature contains various definitions. David A. Garvin classifies quality-related definitions into five categories: transcendent; product-based; user-based; manufacturing-based; and value-based definitions.[12] According to Garvin, the transcendent approach grounds its reasoning on Plato's argument regarding beauty and asserts that quality cannot be defined, but needs to be experienced. The transcendent view illustrates that becoming subjective is the natural characteristic of quality. The product-based definitions claim that quality is an objective and measurable phenomenon; the quality of a product indicates the presence of satisfactory ingredients or features forming the product. The user-based approach focuses on customers' perceptions; customers' satisfaction levels denote the quality of a product or service.[13] J. M. Juran's definition of quality as "fitness for use" falls into this category.[14] The user-based approach, which may also be called customer-satisfaction- or perception-based approach, is a widespread perspective on defining and assessing quality. Tirupathi R. Chandrupatla argues that "[t]he ultimate aim [of quality] is to ensure that the customer will be satisfied to pay for the product or service."[15] Nevertheless, customer

satisfaction-driven quality evaluations may sometimes be unable to reflect quality, and instead reflect only subjective judgments. For instance, W. Edwards Deming shares his experience about how student rating-based teacher assessments cause contradictions; poor teachers may be rated as great teachers, while great teachers may be rated as poor teachers.[16]

The fourth approach consists of the manufacturing-based definitions which concentrate on manufacturing processes and their conformance to requirements or specifications. As Garvin lists, Philip B. Crosby's view on quality in *Quality is Free: The Art of Making Quality Certain* is an example of the manufacturing-based approach.[17] Crosby mentions that "we must define quality as "conformance to requirements" if we are to manage it."[18] In *Quality Without Tears: The Art of Hassle-Free Management*, Crosby formulates this approach as "getting everyone to do it right the first time."[19] Therefore, definitions in this category demand making the best effort in the first place during manufacturing. This perspective has much in common with the product-based approach which attributes quality to the ingredients of the product. Both underscore the importance of the production stages. However, the manufacturing-based approach has a much broader scope covering also all processes of a product or service, not only the ingredients. The last approach of Garvin's classification is the value-based definitions which suggest the combination of a product's or service's degree of excellence and its price. The value-based view recognizes the significance of the ingredients or the excellence of the manufacturing processes, but adds a price-based condition to these requirements.[20]

David A. Garvin also evaluates the five major approaches in accordance with marketers' and manufacturers' judgments and distinguishes the perceptions of marketers from manufacturers on the assessment of quality; marketers perceive quality through user-based or product-based perspectives, whereas manufacturers identify quality by manufacturing-based views. According to Garvin, none of the five categories represents an adequate and appropriate framework to thoroughly address quality and the conflict between perceptions of marketers and manufacturers "can cause serious breakdowns in communication."[21] Furthermore, Garvin states that [r]eliance on a single definition of quality is a frequent source of problems" and suggests an eight-dimension approach to resolve the aforementioned challenges.[22] Garvin explains eight dimensions to elaborate what quality is: performance, features, reliability, conformance, durability, serviceability, aesthetics, and perceived quality. Garvin limits these eight dimensions to product quality in the article entitled "What Does "Product Quality" Really Mean?" in 1984.[23] However, he does not express a similar limitation in the article entitled "Competing on the Eight Dimensions of Quality" in 1987, which means that these dimensions of quality may be applied to services as well.[24]

Parasuraman, Zeithaml, and Berry emphasize three features of services to indicate the differences between services and goods/products and the hardship of appraising service quality: intangibility, heterogeneity, and inseparability. Parasuraman and his colleagues propose a model of service quality which reflects a customer perception-based approach and compares customers' expectations with services' performances. In light of their model, Parasuraman and his colleagues explore 10 dimensions of service quality: access, communication, competence, courtesy, credibility, reliability, responsiveness,

security, tangibles, and understanding/knowing the customer.[25] Additionally, as Owlia and Aspinwall reveal, there are some other scholars, such as Christian Gronroos, J. Stewart and K. Walsh, and John Haywood-Farmer, who develop different models and different quality dimensions to evaluate service quality.[26]

According to Tirupathi R. Chandrupatla, the history of quality goes back to the beginning of human civilization, maybe not in terms of today's concept and context, but in terms of fulfilling the sense of excellence.[27] For instance, the presence of the pyramids is proof of this perfection. In the first four decades of the twentieth century, some substantial academic and empirical studies and works on quality management had been conducted. However, quality and quality management related academic works, research studies, and implementations accelerated after World War II.[28] Albert Weckenmann, Goekhan Akkasoglu, and Teresa Werner examine the changes and developments in quality management from the beginning of the twentieth century to now through four paradigms: quality inspection, process quality, system quality, and total quality management.[29]

The first paradigm encompassed the pre-1940s period, when quality management activities were carried out by inspecting products in order to detect faulty ones. During this period, the primary aim was to produce with the highest possible quality and lowest cost in the shortest time. However, the cost of inspecting each product and fixing defective ones was the main challenge of quality inspection. This situation caused a paradigm shift by placing attention on process quality rather than product quality. The triangle of quality, cost, and time was established to implement processes instead of products. Quality control and quality assurance were applications of the second

paradigm. Quality control changed the focus from separately inspecting the quality of products to controlling the quality of processes. Quality assurance was a step forward for ensuring quality; as a proactive approach, it involved calculating the risks of poor quality and taking necessary measures to avoid those risks. During the second paradigm, quality management was still product oriented; not the final product, but its processes. The second paradigm shift widened the quality-related area by extending the emphasis to the whole system. The ISO 9000 series, certifications, and standardizations arose as a result of the idea of spreading quality to the system. However, the constant shift in focus from the product to the system continued widening through the third paradigm shift. The fourth paradigm included everyone working for the organization in quality management through the concept of total quality management (TQM). TQM does not regard quality as the issue of a particular product, process, or department, but deems it a collective effort and cooperation of the whole organization, from the leadership to each employee.[30]

After clarifying the four paradigms in quality management, Weckenmann and his colleagues reach a conclusion about the current situation, stating that "globalization and resulting complex cross-linked supply chains put new requirements on quality management, demanding not only a technical oriented quality but also the consideration of social responsibility and sustainability."[31] This view on quality management means that quality is no longer merely a concern of an organization or limited to an organization's internal interest; quality management is also a key factor in social, economic, and environmental sustainability. Indeed, this approach denotes the fifth paradigm by shifting the focus from the organization to the society, in terms of the mentioned responsibilities. Therefore, the development of the concept of quality has

continued to consistently widen its domain through the following stages: product, process, system, organization, and society.

5.2.2 Why Quality Matters

The term *quality* is frequently used not only by manufacturing and marketing companies, but also by almost all public and private organizations in all sectors regardless of their size and function. Quality is a very appealing word; the discourse of quality entices people into demanding the product or service at issue. In this sense, due to the positive connotation of the concept, quality is utilized as a tool to persuade people to buy or ask for a product or service. In other words, quality is one of the most substantial means to convince potential customers. In the case of current customers, in general, the aim of quality is to satisfy customers' expectations. For this reason, using technological and communicational opportunities, manufacturers, marketers, and service providers apply rating systems to figure out the customers' satisfaction levels. Moreover, achieving the highest customer satisfaction rates with the lowest possible costs is an essential goal. Chuck Chakrapani mentions that "[q]uality decreases the cost of doing business by increasing efficiency and by eliminating rework and waste. In that process, quality also increases customer and employee satisfaction."[32] In this view, cost, efficiency, and satisfaction are the benefits of quality.

However, even though customer satisfaction is a central issue in order to determine quality in market-related products or services, the presence of different satisfaction scales and some conflicts among these scales are obstacles organizations may face while striving to accomplish customer satisfaction. Additionally, it is possible to come across many customers prior to reaching out to the ultimate customer. For example,

in a product's distribution channel, before the customer, there is a sequential line of the producer, wholesaler, and retailer. Although the ultimate customer is literally named the customer, in reality, the retailer is the customer of the wholesaler, and the wholesaler is the customer of the producer; even the producer might be a customer of someone else if the producer buys the raw materials or some components of the product from another supplier. Moreover, in the event of certain services like those in healthcare and education, the terms customer and customer satisfaction may become more complex matters.[33]

According to Daniel T. Seymour, it is mostly external impulses that compel organizations to pay attention to quality rather than their internal inclinations. Seymour details these impulses as four motivations: competition, cost, accountability, and the weight of services.[34] The aim of gaining the ability to survive in a high competitive environment is the first motivation of the organization to look for quality. Competition is an essential force for both non-profit and for-profit organizations to persuade potential and current customers that they (the organizations) have adequate capacity to meet their (customers') expectations. In other words, in a competitive environment, producing high-quality goods or services is not sufficient to survive; customers must also be convinced that the goods or services satisfy their expectations. The second motivation is to minimize costs. Like competition, reducing costs is a primary goal and motivation for both non-profit and for-profit organizations, which requires improving efficiency through quality management. Accountability is another impulse encouraging organizations to focus on quality. For-profit organizations have a responsibility to their shareholders to prove that the organization does well, whereas non-profit organizations have a responsibility towards their social, political, or religious people, groups, or communities to show that

they work effectively. From this perspective, economic, social, and environmental sustainability-based responsibilities may be evaluated under accountability. The last motivation is about the importance and necessity of the service in all areas. This component means that even in the case of a product, quality is not only pertinent to some technical features, but at the final stage, its acceptability depends on the service provided by the persons/employees who interact with the customers.[35] As mentioned, in the previous subsection, W. Edwards Deming states that he knows of some great professors who have been rated highly by students despite their lack of academic qualifications or achievements.[36] This example may represent the difficulty in measuring the quality of teachers. However, it may also denote the lack of attention attributed to the relationship between professors and students and/or the expectations of the students. In other words, a technically high-quality product or well-organized service cannot be deemed acceptable as long as it is being served in an appropriate manner and in accordance with customers' expectations. In this sense, in a competitive environment, the ultimate phase of the quality process is the service.

5.3 Quality in Education and Healthcare

As in the examples given above, different authors and scholars describe and assess quality from different perspectives. Furthermore, the goals of quality management are varied: improving customer satisfaction; decreasing costs; increasing efficiency; and so on. However, as Geoffrey D. Doherty emphasizes, quality "is a management tool, which can make an effective contribution to improving performance at the institutional level or at a subject or departmental level within an institution. In itself, it will not make

management better or worse."[37] Philip Crosby accentuates the importance of management in quality with harsher words:

> Leaders have to accept the fact that poor management is the reason that things are not done properly in organizations. All the quality-control techniques make very little difference if management is not aimed properly. There is no need to waste time and money on "systems" such as the ISO 9000 and Baldrige. Quality is not produced by a set of books, even if they are used as guides. It comes from the leadership of the organization—most of all, from the leader personally. When attitudes are influenced in the right way, quality takes care of itself.[38]

These statements do not reject the significance of the idea of seeking quality, but highlight the weight of the implementation of quality. Systems, models, or ideas start becoming useful and meaningful by bringing them into practice. Therefore, formulating the concept of quality and quality strategies is an essential factor, but the implementation of them to existing management is crucial as well. In this context, in this section, the application of quality to education and healthcare will be examined succinctly. The ultimate aim of this chapter is to define quality in terms of ethics education in healthcare. The existing sources do not give adequate opportunity to directly elaborate the topic through the studies on 'ethics education in healthcare.' Nevertheless, the lack of relevant academic studies in this specific area necessitates looking at other pertinent fields. In this sense, education and healthcare are the two most relevant areas to bioethics education. For this reason, the perspectives of these two fields will be elaborated to facilitate the understanding of quality in bioethics education.

5.3.1 Perception of Quality in Education

Education is one of the prominent fields in which quality has been discussed intensively since the late 1980s and early 1990s. New journals focusing on quality in education, like *Quality in Higher Education*, have produced the opportunity to debate the

concept of quality in terms of its application to education. During that period, different definitions, approaches, and models were formulated and proposed for a better understanding of the notion of quality and to enhance educational standards.[39] In Europe, the *Bologna Process* started an important initiative to improve educational cooperation, promote higher education, and ensure quality in higher education. The Bologna Declaration was signed by 29 European countries on June 19, 1999. As of 2016, the number of Bologna Process members was up to 48 countries.[40] Furthermore, the MERCOSUR Accreditation Scheme (the educational venture of the South American countries), the Ibero-American Network for Quality and Accreditation of Higher Education (the initiative of the Latin American countries and Spain), and the US Council for Higher Education Accreditation are some other regional organizations concentrating on supporting higher education and strengthening quality in higher education.[41]

Additionally, some international organizations, such as the United Nations Educational, Scientific, and Cultural Organization (UNESCO) and the World Bank, have been making a remarkable and continuous effort to "[e]nsure inclusive and equitable quality education and promote lifelong learning opportunities for all."[42] The Incheon Declaration—which was accepted during the World Education Forum 2015 in Incheon (Republic of Korea) by many international institutions and participants from 160 countries, including: Ministers; heads of delegations, agencies, and organizations; representatives of the private sector and civil society; educators; students; and so on—is the latest international endeavor to determine a new vision for education. In light of internationally acknowledged values, principles, and agreements, the Declaration emphasizes three core principles, recognizing education as (1) a fundamental human right

and (2) a public good as well as (3) gender equality as an essential requirement to fulfill this right. Moreover, the Declaration highlights five features to achieve the primary goal of education: accessibility, equity, gender equality, quality, and lifelong learning.[43] In regard to quality, the Declaration states that:

> An integral part of the right to education is ensuring that education is of sufficient quality to lead to relevant, equitable and effective learning outcomes at all levels and in all settings. Quality education necessitates, at a minimum, that learners develop foundational literacy and numeracy skills as building blocks for further learning, as well as higher-order skills. This requires relevant teaching and learning methods and content that meet the needs of all learners, taught by well-qualified, trained, adequately remunerated and motivated teachers, using appropriate pedagogical approaches and supported by appropriate information and communication technology (ICT), as well as the creation of safe, healthy, gender-responsive, inclusive and adequately resourced environments that facilitate learning.[44]

This clarification places emphasis largely on outcomes of education as acquiring certain knowledge and skills. It also underlines the obligation of applicable teaching methods, appropriate teaching content, suitable teaching environments, teachers' qualifications, and the utilization of technology to obtain expected outcomes. The basic stance of the Declaration is explained as "a humanistic vision of education and development based on human rights and dignity; social justice; inclusion; protection; cultural, linguistic and ethnic diversity; and shared responsibility and accountability."[45] This vision demonstrates the features of the human rights approach. However, the aforementioned statements concerning quality chiefly reflect the main characteristics of the human capital approach.

The human capital view is also known as the economist approach and is represented by the World Bank's standpoint. According to the World Bank, education is one of the most effective and appropriate means to ensure economic growth, peace, and stability as well as to reduce poverty, gender inequality, and economic disparity. The

quantitative outcomes of educational programs, like schooling, enrollment, and retention rates, are the fundamental indicators of the programs' performance.[46] On the other hand, UNESCO's view on education denotes the human right approach, which is also named the progressive approach. As Angeline M. Barrett and her colleagues indicate, the human right approach pays more attention to processes rather than outcomes by evaluating education not merely as a proper way to gain particular knowledge and skills, but also as a decent and ongoing process to attain particular personal, social, and cultural values to improve interpersonal relationships.[47] However, Leon Tikly and Angeline M. Barrett scrutinize the human capital and human right approaches and suggest a third one to assess the quality of education in low-income countries. Tikly and Barrett introduce a social justice-based approach to address: the impact of different educational opportunities on developing learners' capabilities; cultural and institutional impediments; different priorities on the outcomes of education; and the relationship between democracy and the governance of education. This approach requires appraising quality of education not only through the outcomes or processes of education, but also by cultural, social, and economic values and circumstances as well as political climate.[48]

However, the central considerations of both human capital and human right approaches are about improving educational facilities, equity, equality, and quality in primary and secondary education in undeveloped and developing countries. Similarly, Tikly and Barrett's social justice-based approach focuses on the quality of primary and secondary education in low-income countries. Therefore, it would be difficult to assess quality in bioethics education through these approaches. Bioethics education largely

implies higher education, and it should largely be evaluated by higher education related quality descriptions, models, and views.

Studies appraising quality in higher education frequently utilize and/or benefit from the views, approaches, and models regarding quality and quality management which were explored and developed by business, manufacturing, and marketing.[49] W. Edwards Deming's fourteen points for management in business, Joseph M. Juran's views on quality and his concise definition as *quality is fitness for use*, and Philip B. Crosby's major principles *do it right the first time* and *zero defects* as well as his description of quality as *conformance to requirements* are commonly employed perspectives and definitions in the evaluation of quality in higher education.[50] However, the fundamental question is whether the business sector-originated definitions, approaches, and models can be applied to education. The business sector's customer-centered focus, profit-driven private facet, clear objectives, tangible products, and short-term visible outcomes noticeably differ from education's student-based spotlight, public good feature, obscure goals, intangible outputs, and long-term results.[51] Nevertheless, in reality, the presence of such discussions has not precluded the academia from applying almost all market-based quality management models to education.[52] According to Taina Saarinen, studies in the last two decades on quality in higher education have "turned [quality] from a debatable and controversial concept into an everyday issue."[53] In this view, even though there can be certain differences among different fields, there is a fundamental commonality among all quality related studies and works, which is achieving the goal of ensuring or improving the excellence of productions and services they produce or provide.

In regard to being more specific concerning quality in higher education, the following authors' studies are worth mentioning. Lee Harvey and Diana Green's article, entitled "Defining Quality," published in 1993, and both authors' studies in the subsequent period are important sources concentrating on quality in higher education.[54] Moreover, Mohammad S. Owlia and Elaine M. Aspinwall's framework outlining six dimensions is one of the most considerable studies to analyze the concept of quality in higher education.[55] Similarly, examining the seven models introduced by Ying Cheong Cheng and Wai Ming Tam may be useful to understand distinct perspectives on the assessment of quality in education.[56]

Lee Harvey and Diana Green consider quality in higher education a slippery and relative concept due to two main reasons. The first one is about the existence of many stakeholders, each of whom places attention on different aspects of quality. The second reason that makes the concept elusive is the distinctions in the evaluation of distinct circumstances. In one case, quality may be measured by satisfying particular specifications, whereas in another case, it could be gauged only by meeting personal satisfactions without looking for absolute standards.[57] Because of the different perceptions concerning quality, Harvey and Green categorize all the understandings of quality into five classifications: quality as exceptional; perfection or consistency; fitness for purpose; value for money; and transformation. Quality as exceptional assumes quality as a special high-class situation without proving it through any tangible standard or an excellent condition surpassing or at least meeting predetermined requirements. Quality as perfection or consistency is grounded on the combination of Philip B. Crosby's definition of quality as *conformance to requirements* and his *do it right the first time* and *zero*

defects ideas which reflect a preventive approach. Quality as fitness for purpose represents the fulfillment of specific consequences in compliance with objectives. Quality as value for money creates a correlation between costs and obtained results. Quality as transformation acknowledges education as an ongoing transformation process which enhances and empowers the participants to secure improvements. After detailing different arguments about each of the five categories, Harvey and Green conclude that different stakeholders of higher education have different goals, interests, and perceptions; a unique quality definition cannot satisfy the goals, interests, and perceptions of all these parties, and not a quality, but qualities should be defined to meet the expectations of all the stakeholders.[58]

In the article entitled "Defining Quality," Harvey and Green do not declare a particular position in favor of any category of quality. However, in individual articles, Harvey and Green pursue slightly different approaches from each other. In "Understanding Quality" in 2006, Harvey examines the same five definitions of quality and accepts the transformative approach as the most appropriate one to explain quality in higher education. According to Harvey, quality implies a dynamic process leading to changes and developments; it is only the transformative definition that has the potential to generate expected improvements through enhancing and empowering students; the other four approaches only represent static conditions.[59] On the other hand, in "What is Quality in Higher Education? Concepts, Policy, and Practice," Green somewhat changes the aforementioned five approaches and elaborates the concept of quality in higher education through the following perspectives: the traditional approach; conformance to standards; fitness for purpose; effectiveness in institutional goals; and meeting customers'

needs.[60] Green emphasizes the need for describing quality in light of each stakeholders' perspective and says "[t]he best that can be achieved is to define as clearly as possible criteria that each stakeholder uses when judging quality."[61] Although Green renames or alters some approaches, she reaches a conclusion congruent with her previous view that it is not possible to proclaim a unique definition of quality in higher education.

Yin Cheong Cheng and Wai Ming Tam stress a similar point to Harvey and Green that definitions of quality in education vary from person to person in accordance with persons' different interests, concerns, and perceptions. In light of this view, Cheng and Tam expand on seven quality models in education: a goal and specification model; resource-input model; process model; satisfaction model; legitimacy model; absence of problem model; and organizational learning model. According to Cheng and Tam, each model carries certain strengths and weaknesses; the best approach to fulfill quality in education is to benefit from all the models by utilizing the basic foundations of each of them.[62] Even though Cheng and Tam detail the concept of quality in education under seven models and name each one differently from Harvey and Green's five categories, in the case of comparing the two approaches, it can be seen that both underscore the weight of the following notions: different expectations and perceptions; conformance to specifications; personal and institutional goals; transformation; zero defect; focusing on processes; institutional reputation; customer satisfaction; relation between inputs and outcomes; and change and improvement.[63] From this perspective, regardless of how to categorize and label quality approaches, defining, assessing, or measuring quality in education requires attention to all these notions and concerns.

Contrary to the two aforementioned approaches which concentrate on different definitions of quality, Mohammad S. Owlia and Elaine M. Aspinwall expound on the dimensions of quality in education. The central idea of Owlia and Aspinwall's viewpoint is that not only students and their families, but also employers, staff, and governments are "customers of the education system with a diversity of requirements."[64] Owlia and Aspinwall introduce: tangibles, competence, attitude, content, delivery, and reliability as six dimensions of quality in higher education. They consider students customers in terms of all the dimensions; regard academic staff as customers in terms of tangibles, competence, content, and reliability; and count employers as customers in terms of content and reliability. Owlia and Aspinwall's stance indicates that determining each customer group and their perceptions accurately and thoroughly is the fundamental principle of customer satisfaction.[65]

Harvey and Green refer to different views in education as different perspectives of different stakeholders, Cheng and Tam describe them as "the different emphases on different aspects of an educational institution," and Owlia and Aspinwall state that these differences are "different groups of customers."[66] Although the general framework of Owlia and Aspinwall's study is remarkably dissimilar to Harvey and Green's as well as Cheng and Tam's analyses, there is a substantial commonality among all these approaches: quality in higher education cannot be analyzed through a unique definition; education encompasses different stakeholders or parties with different perspectives, expectations, benefits, and needs; achieving quality in education necessitates taking all these differences into consideration.

5.3.2 Quality in Healthcare

Quality is an indispensable concept in healthcare indicating the existence of certain characteristics in healthcare delivery. Similar to quality in education, there are many definitions of quality in healthcare. However, the main difference between these two fields is that quality in healthcare is not as elusive, ambiguous, and contentious as it is in education. Several reasons may be asserted to explain this situation. Nevertheless, one of the primary arguments could be the clarity of healthcare's goals, at least the basic ones. For example, avoiding unnecessary morbidity and mortality as well as ensuring patient safety are some absolute objectives of healthcare. Any intention, activity, or idea aiming to improve the standards of healthcare services must place adequate attention to these goals. Nonetheless, this does not mean that quality-related concerns have completely been eliminated in healthcare. As Lee Harvey highlights, quality refers to a dynamic process that represents shifts and developments.[67] Maybe it is impossible to formulate a quality framework which is credible under all circumstances or which lasts forever. Changes in individuals' and institutions' needs, perceptions, or expectations would instinctively cause changes in a settled quality structure as well.

Avedis Donabedian is a pioneer scholar focusing on the definition, evaluation, and measurement of quality in healthcare.[68] According to Donabedian, quality is a slippery concept, and it is difficult to describe it through a single definition; medical care consists of different components, and instead of judging medical care as a whole, it would be more meaningful to assess each component separately to decide whether the care is good or poor.[69] In *An Introduction to Quality Assurance in Health Care*, Donabedian becomes more specific by delineating quality "as the product of two

factors:" "the science and technology of health care" and "the application of that science and technology in actual practice" which "can be characterized by several attributes that include efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy, and equity."[70] Therefore, Donabedian defines quality in healthcare by specifying the seven components as follows:

> 1. Efficacy: The ability of the science and technology of health care to bring about improvements in health when used under the most favorable circumstances;
> 2. Effectiveness: The degree to which attainable improvements in health are, in fact, attained;
> 3. Efficiency: The ability to lower the cost of care without diminishing attainable improvements in health;
> 4. Optimality: The balancing of improvements in health against the costs of such improvements;
> 5. Acceptability: Conformity to the wishes, desires, and expectations of patients and their families;
> 6. Legitimacy: Conformity to social preferences as expressed in ethical principles, values, norms, mores, laws, and regulations;
> 7. Equity: Conformity to a principle that determines what is just and fair in the distribution of health care and its benefits among members of the population.[71]

The World Health Organization (WHO) uses a similar methodology to appraise quality in healthcare by counting the six dimensions of quality rather than providing an exact definition:

> 1. Effectiveness: Delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
> 2. Efficiency: Delivering health care in a manner which maximizes resource use and avoids waste;
> 3. Accessibility: Delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
> 4- Acceptability/patient-centeredness: Delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
> 5- Equity: Delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;

6- Safety: Delivering health care which minimizes risks and harm to service users.[72]

Donabedian and the WHO emphasize parallel features of good healthcare services including effectiveness, efficiency, acceptability, and equity. The WHO recognizes accessibility and safety as two separate dimensions, whereas Donabedian details these two dimensions under the component of acceptability. On the one hand, Donabedian underlines the conformity to social, ethical, and legal conditions and preferences as the component of legitimacy, while the WHO, on the other hand, acknowledges the importance of these issues by expressing the necessity of paying attention to the culture of patients' communities through the dimension of patient-centeredness.[73] In other words, even though some quality dimensions of the WHO are labeled differently from Donabedian's components, they encompass largely similar contents and place attention on similar characteristics of healthcare services.

Another prestigious institution making efforts to define, analyze, and improve quality in healthcare is the Institute of Medicine (IOM). *To Err Is Human: Building a Safer Health System* and *Crossing the Quality Chasm: A New Health System for the 21st Century* are two classic reports of the IOM illuminating quality and the need for quality in the United States healthcare system.[74] The IOM defines quality in healthcare as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge," and interprets this definition as creating the following benefits: "patient satisfaction and well-being, broad health status and quality-of-life outcomes, and the processes of patient-provider interaction and decision making."[75] *Crossing the Quality Chasm* utilizes this definition and reiterates Donabedian's structure, process, and outcomes-based quality

evaluation model to appraise the quality of healthcare delivery. Additionally, this report determines the six dimensions of quality as:

1. Safety: Avoiding injuries to patients from the care that is intended to help them;
2. Effectiveness: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively);
3. Patient-centeredness: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
4. Timeliness: Reducing waits and sometimes harmful delays for both those who receive and those who give care;
5. Efficiency: Avoiding waste, including waste of equipment, supplies, ideas, and energy;
6. Equity: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.[76]

The only difference between the WHO's and the IOM's quality dimensions is related to the distinction between accessibility and timeliness. The WHO requires healthcare services to be accessible which means healthcare should be delivered in a timely manner as well as allocated congruently with resources, skills, and geographical appropriateness. Nevertheless, the IOM merely focuses on the delivery of healthcare as timely without explicitly pointing out the issue of access to healthcare. This difference may result from the WHO's perspective which considers access to healthcare "one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[77] However, even though the latest healthcare regulation, the Patient Protection and Accountable Care Act, reflects a similar approach, the United States is still behind on the philosophy recognizing access to healthcare as a human right.

As a result, Donabedian's, the IOM's, and the WHO's stances on quality in healthcare demonstrate that defining quality is not an easy task because healthcare

contains various aspects, but it is possible to clarify the components of quality. The historical sequence in the development of quality in healthcare indicates that the IOM benefited from Donabedian's views, while the WHO employed the IOM's perspective with very slight changes. This situation proves that although it may be difficult to give a single definition, the consensus on the dimensions of quality facilitates the understanding of quality in healthcare.

5.4 Quality and Bioethics Education

Medical ethics has a long history, from the School of Hippocrates to the Judeo-Christian religious tradition and from Percival's medical ethics to the American Medical Associations' ethical codes.[78] Therefore, physicians have practiced medicine with particular moral norms since the Hippocratic Oath. However, until the third quarter of the twentieth century, traditional medicine continued to reign over medical practices, which was mostly physicians' benevolence—driven without patients' participation in decision-making processes.[79] By the 1970s, the term *bioethics* began to attract widespread attention by emphasizing the priority of the patient's autonomy and the patient's involvement in decision-making processes. As Henk ten Have underlines, Van Rensselaer Potter was the first person to use the term *bioethics* as a new concept. Potter's view on bioethics reflects a comprehensive approach encompassing not only the patient's individual autonomy in medical processes and procedures, but also the awareness of social good, the recognition of environmental implications, and the consideration of a global attitude to ethical issues. Indeed, today, this extensive perspective is largely embodied under global bioethics. Nonetheless, bioethics driven changes and

developments in ethical values, norms, and principles clearly prove that today's medical ethics is far different from the traditional medical ethics.[80]

In regard to ethics education in bioethics, the essential issue is whether there is a need to explore a new quality model for bioethics education because it may be comprehended merely as a sub-area within education. In other words, it might be argued that bioethics education is a part of education not demanding a distinct model to assess its quality. In this view, prior to defining quality in bioethics education, it would be beneficial to expound on why bioethics education requires a particular conceptualization of quality.

5.4.1 Need for Defining Quality in Bioethics Education

Ethics has mattered in medical conduct since the time of Hippocrates. Nevertheless, formal ethics teaching is fairly new to healthcare related schools. Albert R. Jonsen highlights the absence of ethics courses and lack of relevant literature when he started to work as a professor of bioethics at the University California in 1972 and explains how medical ethics literature, medical ethics pertinent activities, and teaching ethics programs bloomed in the subsequent years.[81] But today, according to the Global Ethics Observatory (GEObs) databases, numerous schools and institutions worldwide provide various bioethics programs.[82] As McCullough and Ashton underscore, this variety brings about advantages and disadvantages; each program may signify a distinct methodology with "its own powerful insights and applications," but also the variety could impede the creation of a standard of teaching ethics.[83]

The concept of quality, especially quality assessment or quality measurement, relies on the presence of standards and implies the conduct of best practices. Non-

standardization does not mean poor quality per se, but talking about quality necessitates the existence of particular standards and indicators. In this sense, all quality models either explicitly or implicitly convey some level of standardization. However, it is questionable whether only one type of ethics teaching is possible, and if so, whether it is profitable. Such a debate resembles the discussion concerning whether to analyze ethical matters through predetermined principles. It is obvious that teaching ethics is completely different from producing a car, serving in a restaurant, or teaching scientific facts; the nature of ethics contains dissimilar moral values, norms, and principles due to individuals' different cultural, religious, and philosophical backgrounds. For this reason, the teaching of these differences may entail distinct methodologies. Nevertheless, evaluating the effectiveness and performance of an ethics program does not require a standard form of teaching because quality in ethics education is not associated with imposing fixed values, but fulfilling determined goals. In short, appraising the quality of rapidly increasing ethics programs in the fast-growing field of bioethics would not undermine the diversity; on the contrary, it would facilitate the development of good practices and guide relevant stakeholders by illustrating favorable applications.

On the other hand, in terms of the relationship between quality in education and quality in bioethics education, it might be stated that quality models which are already available in education may be applied to bioethics education as well. Nevertheless, there are two major challenges associated with this. First, as the examples above illustrate, each author defines quality of education distinctly from another, hence it may be difficult to directly adopt one of them to bioethics education. Additionally, it would be difficult to claim that the description and measurement of quality have been settled in the field of

education. Second, defining quality is closely related to goals. In manufacturing, marketing, or education, there is always a correlation between describing quality and identifying goals. If the goal is to produce a durable product, the quality would mostly be defined in light of technical features, but if the aim is to generate high customer satisfaction, the quality would chiefly be characterized by customer expectations and the ways to make them satisfied. In other words, any change in goals influences the perception of quality. In this context, bioethics education's unique goals require drawing a unique framework for quality in bioethics education.

5.4.2 Quality in Bioethics Education

As elaborated above, the WHO recognizes the quality of healthcare in the scope of six dimensions: effectiveness, efficiency, accessibility, patient-centeredness, equity, and safety. Bioethics is an essential component of healthcare, and it is supposed to create a positive contribution to healthcare services and their quality. Thus, the American Society for Bioethics and Humanities (ASBH) describes the general goal of healthcare ethics consultation as "to improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns."[84] This means that there is a direct correlation between bioethics activities and healthcare quality. Therefore, bioethics education should take the dimensions of healthcare quality into consideration when framing its perspective on quality. In terms of the connection between bioethics and healthcare services, it may be stated that bioethics education should utilize its own methods, means, and goals to improve healthcare professionals' ethical knowledge, skills, and behaviors in order to produce effective, efficient, accessible, patient-oriented, equitable, and safe healthcare services.

On the other hand, in regard to the relationship between bioethics education and quality in education, in the case of evaluating the approaches indicated in the previous section, it is possible to describe quality in light of Harvey and Green's following quality definitions: *quality as fitness for purpose*; *quality as transformation*; and *quality as effectiveness in achieving institutional goals*. Even though Harvey and Green assess more definitions of quality than these three, it is believed that these three definitions are the most relevant, functional, and worthy ones to appraise quality in bioethics education.[85] According to Harvey and Green, *fitness for purpose* may be appraised in light of customer specification and institutional mission. Customer specification requires meeting the customer's requirements, while institutional mission entails fulfilling the provider's goals.[86] Customer specifications, requirements, or expectations could be important when determining the quality of many products and services. However, defining the quality of bioethics education through the specification of the customer has several challenges. It is difficult to decide who the customers of bioethics education are, whether students, the students' families, healthcare institutions, healthcare receivers, someone else, or all these parties as different stakeholders of healthcare. In the case of a customer-based approach, students or participants should be counted as the only or primary group of customers. Defining bioethics education and its quality in the scope of students' specifications implies that students are sufficiently qualified to shape the general structure of bioethics education. Nevertheless, such an assumption may be considered overly optimistic, even utopic. This does not mean that students' expectations are without worth; on the contrary, as a key stakeholder, students' perceptions on education are valuable and need to be taken into consideration, as contributors, but not as the main determinants. In comparison

with customer specification, institutional mission is more applicable to bioethics education, not only due to institutional capability, qualification, and experience, but also due to the institutional motivation to be able to survive in a competitive environment. Unable to meet requirements and expectations would lead institutions to lose their ground and reputation which might cause the termination of the institutions.

Transformation is another crucial approach to define quality in education. Harvey and Green regard education as an ongoing transformative process to enhance students' or participants' knowledge, skills, and abilities as well as empower students or participants to engage in the relevant processes.[87] As Harvey clarifies and underscores in the article entitled "Understanding Quality," education is a continuous process which aims to create a transformation in the intellectual development of students.[88] In this view, it is possible to assert that each type of education at all levels has an explicit purpose of improving learners' or participants' knowledge, skills, abilities, or behaviors in a transformative manner. However, certain concerns may emerge regarding how to determine the content, scope, and prevalence of transformation. At that point, quality as *effectiveness in achieving institutional goals* (as one of Diana Green's classifications) could be helpful to regulate these aspects of transformation. Green explains this definition of quality as a form of *fitness for purpose* which indicates the accomplishment of institutionally determined goals.[89]

In this view, it can be highlighted that institutional missions, purposes, or goals are decisive indicators to describe quality in education. However, a major challenge of this approach is the determination of purposes or goals.[90] Defining quality in light of unclear goals would cause ambiguity. Nevertheless, forming well-defined goals would

help to draw a framework to define quality. In this context, Ercan Avci utilizes Kohlberg's cognitive-developmental approach, Handelsman et al.'s ethical acculturation model, and the Delors Report's "learning throughout life" concept to elaborate the goals of ethics education in healthcare as: increasing ethical knowledge; improving ethical skills to strengthen ethical sensitivity, awareness, and judgment; developing ethical behavior; and promoting cultural competence.[91]

From the perspectives of all the mentioned approaches and assessments, as well as Avci's specification regarding the goals of ethics education in healthcare, it can be deduced that bioethics education is an ongoing transformative process aiming to achieve the aforementioned four specific goals, and quality in bioethics education is the conformance to these goals. Defining quality in bioethics education as *conformance to the goals* has the potential to create certain characteristics which are advantageous. First of all, this is a functional, definite, and objective definition; it is functional because it illustrates practical purposes, such as increasing ethical knowledge; it is definite because it suggests particular goals, like improving ethical skills; and it is objective because it does not impose a specific belief, value, or principle; it proposes promoting cultural competence to be cognizant of all kinds of differences. Second, in the scope of Harvey and Green's view, this definition encompasses a transformative approach which demands the enhancing and empowering of learners to fulfill a continuous improvement in their ethical sensitivity, awareness, and judgment.[91] Learners' cognitive, vocational, and communicative development, along with their engagement in ethical discussions and evaluations, are essential for accomplishing quality in bioethics education. Third, this designated goals-based definition recognizes individual, social, and cultural diversity and

encourages a peaceful togetherness. Ethics education does not only refer to the teaching of particular codes and principles, but also the awareness of and respect for differences. Finally, the functional aspect of the definition requires ensuring effective, efficient, accessible, patient-oriented, equitable, and safe healthcare services. The ultimate goal is to produce, provide, and deliver quality healthcare. For this reason, teaching or learning ethics should engender practical outcomes in healthcare services.

Furthermore, it is important to note that bioethics is a unique field that contributes to the overall quality of healthcare by establishing, promoting, and implementing ethical values, standards, and principles. In this sense, bioethics education should not be appraised through the concepts and approaches of manufacturing, marketing, or business. Bioethics education is neither a product nor "a service for a customer but an ongoing process of transformation of the participant."[92] Therefore, none of the quality definition classifications categorized by David A. Garvin (transcendent, product-based, user-based, manufacturing-based, and value-based definitions) accurately reflects quality in bioethics education.[93] Subjective and ambiguous phrases such as 'excellence' or 'high standards'; product-oriented approaches like 'quality of ingredients' or 'zero defects'; customer-driven perspectives which give priority to 'customer satisfaction'; or value-based assessments which acknowledge quality as 'value for money' are not adequate to exhibit the definition of quality in bioethics education. For this reason, specifying the aim of bioethics education with the aforementioned four particular goals and describing quality as *conformance to these goals* would produce a measurable, objective, and functional definition.

5.5 Conclusion

Bioethics education is a progressively growing field with various educational institutions and programs across the world. Nevertheless, it is difficult to talk about a commonly agreed teaching program and quality assessment model in this developing academic area. Quality is a contentious and multidimensional concept, but also an attractive one, which inspires individuals and organizations with its aspect of excellence. The examination of different arguments concerning quality illustrate that it may not be feasible to explore an all-inclusive definition of quality to be able to satisfy all product and service territories due to the distinct features, purposes, and requirements of each product or service. As the intersection of healthcare, ethics, and education, bioethics education carries unique characteristics and objectives. For this reason, defining quality in bioethics education should demonstrate its exclusive components and goals. Furthermore, the definition should indicate functional, objective, and measurable attributes in order to become applicable, acceptable, and verifiable. In this view, quality in bioethics education is defined as *conformance to the goals*. This definition shows that quality in bioethics education is an ongoing transformative process to increase ethical knowledge, improve ethical sensitivity, awareness, and judgment, develop ethical behavior, and promote cultural competence.

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6 Chapter - Determining Quality Standards and Indicators in Bioethics Education

6.1 Introduction

Bioethics education has been developing firmly since the beginning of the 1970s with the growth of the bioethics field.[1] The United Nations Educational, Scientific and Cultural Organization's (UNESCO) Global Ethics Observatory, which is "a system of databases with worldwide coverage in bioethics and other areas of applied ethics in science and technology," shows that the number of ethics institutions in five different regions: Africa; the Arab States; Asia and the Pacific; Europe and North America; and Latin America and the Caribbean is 40, 19, 78, 353, and 69, respectively.[2] These figures only denote the registered institutions, which means the exact number of bioethics and applied ethics institutions around the world is most likely much higher than the total of these 559 institutions. However, this data proves that teaching bioethics is a worldwide phenomenon. Furthermore, according to Lisa M. Lee and Frances A. McCarty, in the United States, between 2003 and 2013, the number of educational institutions providing postsecondary degrees in bioethics and applied ethics increased from 1 to 10 in bachelor's degrees, from 4 to 30 in master's degrees, from 1 to 14 in certificates, and from 2 to 6 in doctoral degrees.[3]

In 1973, the Institute of Science, Ethics and the Life Sciences (The Hastings Center) established a commission to examine the current situation in bioethics education and formulate teaching standards.[4] The effort to facilitate and disseminate teaching bioethics continued with UNESCO's *Bioethics Core Curriculum,* whose first section,

"Syllabus," was published in 2008, and second section, "Study Materials," was published in 2011.[5] Additionally, in 2016, the Presidential Commission for the Study of Bioethical Issues (the Bioethics Commission), which was the seventh and last commission of the series of the presidential commissions in the United States, released its report, *Bioethics for Every Generation.* The report emphasizes the importance of democratic deliberation in decision making, lifespan ethics education, and the education of bioethicists.[6] These three works exemplify the local, national, and international institutions' interest in bioethics education. However, this interest is not an arbitrary enthusiasm, but a requirement resulting from globalization and its impact on bioethical issues.[7]

Nevertheless, despite these endeavors and developments, it is still difficult to talk about a consensus on the way to teach bioethics, the impact of teaching bioethics, and the standards for effective bioethics education.[8] Furthermore, studies reveal that the effectiveness of the existing programs, not only in bioethics teaching, but also in ethics education, is questionable.[9] Moreover, even though in some other disciplines, such as business, the influence of ethics programs is assessed in light of certain quality approaches, in the bioethics field, there are very few comprehensive works elaborating the goals of bioethics teaching, defining quality in bioethics education, and delineating the quality standards of teaching bioethics.[10] In this view, this chapter aims to formulate a general framework to address quality standards and indicators in bioethics education in order to measure the effectiveness of bioethics teaching. This chapter begins with clarifying some quality-related concepts and justifying the utilization of an indicator-based approach in quality assessment. Furthermore, the chapter revisits some issues that were examined in the previous chapters, such as the definition of quality in bioethics

education and the goals of bioethics education, to maintain the integrity of the present chapter. The chapter continues by examining Donabedian's three approaches: structure, process, and outcome to explore a methodology for assessing quality in teaching bioethics. After describing the terms *standard* and *indicator*, the chapter concludes by separately pinpointing standards and indicators for structure, process, and outcome measures.

6.2 Some Clarifications

In the case of studying quality, it is possible to encounter many phrases including quality control, quality audit, quality assurance, quality measurement, quality assessment, quality management, and total quality management. In this section, these terms will be succinctly described to indicate how they are understood. Furthermore, in this dissertation, quality assessment in bioethics education is grounded on gauging certain indicators. However, this method is not the only way to evaluate quality. Additionally, as Maureen Tam addresses, indicators-based quality evaluations in higher education are criticized by different scholars because of distinct arguments.[11] For this reason, in this section, some pertinent views are also debated to elucidate why an indicator-based approach would be chosen to measure quality in bioethics education.

6.2.1 Defining Quality-Related Concepts

In quality-related chapters, it is possible to encounter many noun phrases with the term *quality*, such as quality control, quality assurance, and quality assessment. Even though each phrase has its own specific meaning, all these terms are linked to ensuring or fulfilling quality. In other words, all quality-associated concepts highlight different sections of quality management. The glossary in *Juran on Leadership for Quality: An*

Executive Handbook describes *quality management* as "[t]he totality of ways for achieving quality" that "includes all three processes of the quality trilogy: quality planning, quality control, quality improvement."[12] Similarly, the glossary in *ISO 9001: 2000 in Brief* explains quality management as the "aspect of the overall management function that determines and implements the quality policy."[13] These definitions reveal that quality management is an umbrella term that encompasses all quality-related activities and concepts. In this view, quality control, quality assurance, quality assessment, or other pertinent phrases indicate particular capacities in quality management.

In this context, *ISO 9000: 2000* considers *quality control* a dimension of quality management that sheds light on quality requirements.[14] The glossary in *ISO 9000 Quality Systems Handbook* delineates this concept as the "process for maintaining standards of quality that prevents and corrects changes in such standards."[15] Maureen Tam defines quality control as "a system to check whether the products produced or services provided have reached the pre-defined standards."[16] Rupert Gedye compares inspection with quality control and emphasizes the comprehensiveness of quality control by highlighting its main attribute, which is looking at all the stages and processes of a product or service.[17] According to J. M. Juran, quality control has three steps: "evaluat[ing] actual quality performance," "compar[ing] actual performance to quality goals," and "tak[ing] action on the difference."[18] The third step makes Juran's definition much broader than the others; his approach transcends examining pertinent quality requirements or standards and also requires taking certain actions in the case of detecting any difference between predetermined quality goals and actual performance.

Quality assurance is also a part of quality management. Maureen Tam explains quality assurance as "a system based on the premise that everyone in an organization has a responsibility for maintaining and enhancing the quality of the product or service."[19] According to Tam, the key feature distinguishing quality assurance from quality control is that the former focuses on detecting defects, while the latter also aims to prevent defects.[20] Albert Weckenmann and his colleagues make a similar connection between quality control and quality assurance; they deem the primary function of the former as overseeing quality by "control[ling] the quality of products and processes" and accept the essential characteristic of the latter as assuring quality by anticipating "possible risks and problems" and taking necessary measures to avert them in advance.[21] However, Avedis Donabedian counts quality assurance as a wider concept by analyzing it as "all actions taken to establish, protect, promote, and improve" quality.[22] Donabedian's stance on quality assurance recalls the definition of quality management due to its broad scope of activities, all aimed at achieving quality. On the other hand, the glossary in *Juran on Leadership for Quality: An Executive Handbook* represents a completely different approach to quality assurance, defining it as "[a]n independent evaluation of quality-related performance, conducted primarily for the information of those not directly involved in conduct of operations but who have a need to know."[23] These distinct definitions demonstrate that there are several different perspectives on quality assurance.

Quality assessment is another relevant concept denoting "the documentation and evaluation of" quality.[24] Eleanor Gilpatrick concentrates on quality in healthcare and regards quality assessment as "the evaluation of the care provided by an organization."[25] Maureen Tam studies quality in higher education and considers quality assessment "a

means of assessing the quality of what is actually provided by institutions."[26] As these definitions point out, quality assessment is an activity that aims to capture a picture of an organization in order to display the actual situation regarding quality. Even though quality assessment carries some features resembling quality control, quality assessment is not equal to quality control. Both quality assessment and quality control analyze the activities of an organization to explore and evaluate the current situation of those activities from a quality perspective. Furthermore, both compare the existing performances with the predetermined goals and standards. However, the main purpose of quality control, as part of quality management, is to pinpoint deficiencies and give the organization the opportunity to develop new policies and strategies to avoid the repetition of those deficiencies. In this context, quality control functions as a process for achieving quality. On the other hand, quality assessment appraises the actual situation regardless of the reason behind conducting the assessment. Of course, the results of quality assessment can be utilized to improve quality, but it is not a prerequisite of carrying out such an evaluation. In other words, as a requirement, quality assessment does not encompass the third step of quality control which is defined by J. M. Juran as taking action on the differences between the actual performances and the quality goals or standards.[27]

From this perspective, in this dissertation, quality assessment, quality evaluation, and quality measurement are used interchangeably. In respect of quality in bioethics education, quality assessment means to evaluate the actual performance of a bioethics program or course in accordance with the quality indicators elaborated in the previous chapter. The rate of difference between the actual performance of a program and the indicators determines the level of quality, whose calculation will be expounded in the

next sections. Obtaining reliable and valid results is the principal goal when evaluating the quality of bioethics education. Quality assurance or quality improvement that refers to "increasing the ability to fulfill quality requirements" is out of the scope of this dissertation.[28]

Prior to moving on to the next section, it is important also to clarify the concept of total quality management and its relation to the model proposed by this dissertation. *Total quality management* (TQM) is a recent trend as well as a paradigm shift in quality management and has been implemented by many sectors including the education and healthcare sectors.[29] According to Gopal K. Kanji and Mike Asher, "TQM involves continuously satisfying customer requirements at lower cost, by harnessing the commitment of everyone in the organization."[30] Kanji and Asher delineate two prominent attributes of TQM as "people-based management," which refers to the responsibility of everyone in an organization, and "continuous improvement," which requests that quality not be considered a short-term project, but a continuously improving process.[31] Leo H. Bradley underlines the paradigm shift-based feature of TQM and lists the requirements of this approach as "the client priority, the lack of hierarchy, self-monitoring and inspection, collaboration, horizontal communication, cooperation, flowcharts, and team responsibility."[32] These statements show that TQM is a comprehensive approach to quality management that counts quality as a continuous process demanding the commitment and cooperation of all individuals working for an organization.

The model elaborated by this dissertation carries certain similarities to TQM. For instance, comprehensiveness and cooperation are two key features in both. TQM necessitates an all-inclusive institutional collaboration and effort that includes everyone

from the leadership to the employees. The proposed model named *Quality in All Levels* (QAL) also demonstrates a comprehensive approach by examining quality in bioethics education in three levels: structure, process, and outcome. QAL entails meeting certain standards in these three levels simultaneously. In other words, QAL does not only look at the outcomes of bioethics education, but requires particular standards in all the levels. Furthermore, like TQM's people-based management characteristic, besides teachers' qualifications and productivity, QAL values learners' readiness and participation as well as the communication between teachers and learners to achieve quality. Another affinity between TQM and QAL is the significance of the process in both approaches. According to Chung-Yang Chen and his colleagues, the process is a "driving force" and unifying element in TQM to ensure continuous quality improvement.[33] The process has a similar role in QAL by creating the connection between the structure and outcomes.

However, the presence of these commonalities does not make QAL a model or version of TQM. Firstly, TQM aims to continuously improve quality, while QAL only intends to evaluate quality. Secondly, TQM deems customer perception and satisfaction to be an indispensable factor in quality management, even in the case of applying TQM to education, whereas QAL sheds light on the goals of bioethics education without reflecting a customer-driven characteristic.[34] Finally, TQM consists of several critical dimensions including leadership, human resource management, and technical and information systems, all of which must be actively and cooperatively available.[35] However, as a normative approach, QAL assumes the existence and well-functioning of many internal and external components, including organizational commitment,

leadership, and human resources. In this sense, QAL is a model assessing quality in bioethics with its unique perspective while sharing some comparable aspects with TQM.

6.2.2 Utilizing Indicators in Quality Measurement

As elaborated in the next sections, QAL is established on an indicators-driven approach to assess quality in bioethics education. The utilization of indicators denotes that the method aims to generate objective and quantitative criteria to investigate the performance of activities in a field.[36] Some sources classify indicators as *quality indicators* and *performance indicators*.[37] However, this dissertation uses the term *indicator* as a statement addressing a precise situation in the structure, process, or outcome, without engaging in the debate about the abovementioned distinction.

Indicators-driven methods are used by different sectors including the education and healthcare sectors as a measurement tool in quality management. It can be asserted that employing indicators in healthcare or education is the reflection of evidence-based practices.[38] Evidence-based approaches are extensively applied by the healthcare sector to provide evidence of reliable and scientifically valid clinical practices and processes.[39] There is a general acceptance that evidence-based methods can be implemented by the education sector as well to explore evidence of best policies, practices, and principles.[40] Robert E. Slavin emphasizes the importance of evidence-based policies and practices in education to highlight their positive role to increase accountability.[41] In this view, determining measurable indicators and conducting a reliable and objective assessment can help to find solid evidence of excellent educational structures, processes, and outcomes. In other words, measuring quality in bioethics education through certain indicators means transforming an abstract format into a concrete evidence-based one.

According to Geoff Pugh, Gwen Coates, and Nich Adnett, performance indicators in education create certain advantages. Firstly, indicators illustrate the performance of educational institutions and help policymakers appraise their accountability. Secondly, indicators produce information that assists in the allocation of resources. Thirdly, indicators provide future students with useful information for deciding whether to attend the institution. Fourthly, indicators give the institution the opportunity to publicize its performance. Fifthly, indicators are also helpful tools when specifying the goals of the institution. Finally, indicators supply comparable information regarding the performance of different institutions.[42] All these anticipated outcomes are based on the assumption that indicators generate reliable, accurate, and thorough information about the performance of educational institutions.

However, as Maureen Tam demonstrates, using examples from the literature, there are various debates discussing the acceptability of indicators-oriented quality measurements due to the inputs- and outputs-centered quantitative perspective of indicators.[43] David Buck and his colleagues look at the utilization of performance indicators in healthcare and claim that indicators only measure inputs, not performances, and that they "compare differing environments with different levels of need and demand."[44] Pierre Lucier evaluates the implementation of performance indicators in education and asserts that due to merely paying attention to quantitative points without touching on qualitative issues, indicators do not have the ability to portray an accurate and thorough picture in education.[45] On the other hand, Geoff Pugh, Gwen Coates, and Nich Adnett cite R. Meyer to emphasize three key matters involved in determining valid performance indicators in higher education: *outcome validity* that requires indicators to

be able to measure and focus on outcomes considered important by society; *noncorruptibility* that sheds light on the potential consequences of indicators and demands that indicators avert undesired outputs such as causing cheating or preventing innovation; and *valid measurement* that means to formulate indicators which carry the capacity to gauge "the institution's own contribution to the overall outcome."[46]

The abovementioned arguments reveal that the primary objection about indicators-based performance or quality assessment is the idea that indicators only consist of quantitative benchmarks and "measure the technical relationship between inputs and outputs."[47] However, as clarified in the next sections, the indicators proposed by the present dissertation do not only encompass quantitative measurements. On the contrary, the overwhelming majority of the indicators entail qualitative assessments. Furthermore, QAL is not a model merely paying attention to inputs and outputs; it underscores the indispensability of the process in bioethics education. According to QAL, quality does not only depend on well-organized structures and favorable outcomes, but also well-implemented processes. QAL regards bioethics education as an ongoing transformative process and deems process indicators as essential links between structure indicators and outcome indicators. For this reason, QAL strives to formulate indicators in a comprehensive manner through quantitative and qualitative benchmarks to reduce the concerns about indicators-based quality assessments.

6.3 Some Questions

As a dimension of quality assessment, determining standards and indicators first requires clarifying certain concepts like the word *quality*; otherwise, some confusion may be caused regarding the meaning of the terms used. In particular, specifying the meaning

of quality is necessary to be able to proceed with other stages in quality assessment.[48] From this perspective, in the present section, the answers to three questions: what quality is, what the goals of bioethics education are, and who the customer is, will be investigated concisely. However, due to various arguments about each of these questions, it is not the purpose of this dissertation to provide never-ending debates, but to briefly point out the pertinent discussions prior to declaring the stance of this chapter on these issues.

6.3.1 What is Quality in Bioethics Education?

The history of quality goes back to the beginning of human civilization regarding its general meaning of the degree of perfection and accuracy.[49] However, as a systematic approach in manufacturing, it appeared at the beginning of the 20th century to deal with mass production-based failures and dissatisfaction, and gradually grew over time.[50] Quality is considered a manufacturing-originated concept with the primary motivation of higher profit.[51] Quality is a very popular word used everywhere to indicate the excellence of products and services. Nevertheless, when it comes to the description of quality, numerous approaches and definitions surface with an understanding of challenges in explaining what quality is. For instance, statements like "a slippery and vague concept," "an elusive concept," "a complex and multifaceted concept," and an "over-used" concept are some examples of acknowledging this difficulty.[52]

As Tirupathi R. Chandrupatla expounds, W. Edwards Deming, Joseph M. Juran, and Philip B. Crosby are pioneers in the 20th century working on quality and quality systems.[53] In *Out of the Crisis*, W. Edwards Deming explains fourteen points for improving quality in business; Joseph M. Juran regards quality as "fitness for use;" and

Philip B. Crosby defines quality as "conformance to requirements" and accentuates two central principles as "getting everyone to do it right the first time" and "zero defects."[54] Even though their focuses were on quality in manufacturing, marketing, and business, these three scholars' ideas and approaches have been utilized by others to also examine quality in other fields, including education.[55] However, the primary debate is whether customer- and profit-driven definitions and models of business should be applied to education.

Quality models in manufacturing, marketing, or business chiefly devote attention to customers' expectations and satisfaction, both in the event of producing products and services. In other words, they largely define quality according to the customer's perspective and perception. Therefore, the essential problem in implementing business-based quality models to education is associated with the matter of whether students should be considered customers.[56] Pak Tee Ng claims that "customer-driven quality management models from the business sector break down when a student is compared with a business customer. A quality education model requires a wider consideration of stakeholders, such as students, teachers, parents, society and business."[57] Lee Harvey and Diana Green also highlight the main characteristic of education as encompassing several stakeholders. Moreover, they believe that due to the distinct needs, requirements, or expectations of each stakeholder, it is impossible to provide a single definition of quality in education to satisfy all the different parties simultaneously.[58] However, as Clare Chua emphasizes, the effort to benefit from another discipline's models does not require directly applying the exact concepts to education; the aim is to borrow the quality-related

philosophies of the pertinent fields and adapt them to education without ignoring each discipline's unique features.[59]

Quality in education is described differently by different texts on the grounds of distinct perspectives. For example, "fitness for purpose," "conformance to specification," and "effectiveness in achieving institutional goals" are some of the definitions used for quality in education.[60] Furthermore, according to Avedis Donabedian, who is a pioneer introducing quality in healthcare, "quality consists in the ability to achieve desirable objectives using legitimate means."[61] Even though these definitions may contain some distinctions, it is feasible to interpret them in the same manner because of their common emphasis on goals or requirements. However, the fundamental questions are which goals or requirements, and how these goals or requirements should be determined. Additionally, attention should also be drawn to the functionality, objectivity, and measurability of goals or requirements. In this view, in this chapter, quality in bioethics education is defined as *conformance to the goals* to generate an applicable and measurable quality model. It is important to note that *conformance to the goals* does not refer to all types of goals, but particular ones that will be delineated in the following subsection.

6.3.2 What are the Goals of Bioethics Education?

The establishment of the Commission on the Teaching of Bioethics, as an initiative of the Hastings Center, is the first comprehensive effort to formulate a framework for bioethics teaching. The Commission was appointed in 1973, and the report, *The Teaching of Bioethics,* was published in 1976.[62] After explaining what bioethics is, the report focuses on determining the goals of bioethics education. Even

though the report acknowledges the possibility of forming distinct goals for distinct educational levels, it forges four general goals for teaching bioethics: "identifying and defining moral issues"; "developing strategies and analyzing moral problems"; "relating moral principles to specific issues and cases"; and "training a group for careers in bioethics."[63] The first three goals aim to strengthen the student's knowledge, skills, and abilities to identify, analyze, and resolve ethical issues and conflicts, whereas the fourth one is intended to train people who want a career in bioethics.[64]

They may not be as detailed as *The Teaching of Bioethics*, but some other bioethics education-related chapters have also investigated the goals of bioethics teaching since the birth of bioethics. For instance, in 1980, Daniel Callahan specified the goals of ethics teaching as: "stimulating the moral imagination"; "recognizing ethical issues"; "eliciting a sense of moral obligation"; "developing analytical skills"; and "tolerating—and reducing—disagreement and ambiguity."[65] Furthermore, Ercan Avci determines the goals of bioethics education by integrating three approaches: Kohlberg's cognitive-developmental perspective; Handelsman et al.'s ethical acculturation model; and the Delors Report's concept, "learning throughout life". According to Avci, bioethics education has four goals: "(1) increasing ethical knowledge; (2) improving ethical skills to strengthen ethical sensitivity, awareness, and judgment; (3) developing ethical behavior; and (4) promoting cultural competence."[66] Additionally, he states that the first three goals are traditional purposes of teaching ethics which have been addressed before by various texts, but the objective to promote cultural competence is a new, but necessary goal of contemporary bioethics education.[67]

The above-mentioned approaches encompass fairly similar goals. The major difference between them is largely to do with the final goal of each approach: *The Teaching of Bioethics* suggests "training a group for careers in bioethics"; Callahan recommends "tolerating—and reducing—disagreement and ambiguity"; and Avci proposes "promoting cultural competence."[68] The recommendation of *The Teaching of Bioethics* to create a bioethics academia was a significant goal during the period when bioethics was only just emerging and trying to become a discipline. In 1973, Daniel Callahan underscored that the field of bioethics had several shortcomings, one of which was not having its own experts and instead having people from theology or philosophy teach bioethics.[69] However, bioethics today is a multidisciplinary field that is growing remarkably, with impressive literature, abundant teaching institutions, and plentiful bioethicists.[70] For this reason, there may no longer be a need for having such a goal.

Callahan's goal to tolerate disagreement and Avci's objective to promote cultural competence are built on parallel grounds; both acknowledge the inevitability of certain conflicts on some ethical issues and try to find an amicable settlement in the event of experiencing disagreements.[71] Nevertheless, a notable advantage of Avci's approach is that it does not merely point out the presence of disagreements in bioethics, but also indicates a resolution to potential conflicts by aiming to improve cultural competence.[72] Moreover, in terms of the impact of ethics teaching on students' or learners' behavior, Callahan considers this issue a low priority goal, while Avci regards it as a main goal.[73] However, Avci does not evaluate this goal in terms of directly changing learners' behavior, but he claims that bioethics education may contribute to learners' ethical behavior.[74]

Joseph R. Betancourt and his colleagues describe cultural competence in healthcare, and when applying their definition to bioethics education, it may be said that cultural competence is to learn the importance of individuals' cultural, social, and religious beliefs on their behaviors, expectations, and decisions in bioethical matters, to be aware of these influences, and to understand the need for taking the differences into consideration when encountering any individual with these beliefs.[75] In this view, bioethics learners should receive a broad outlook on cultural, social, and religious diversity through bioethics teaching. Nevertheless, this education should not cause the creation of new stereotypes or biases, in terms of stigmatizing a group of people with particular assumptions. For this reason, the focus should be on teaching and learning about the existence of cultural, social, and religious distinctions, not on categorizing individuals into predetermined classifications. In light of these clarifications, the four goals mentioned by Avci can also be recognized as the goals of bioethics education in quality assessment (in this dissertation quality assessment and quality measurement are used interchangeably).

Evaluating the appropriateness of these goals is another important manner. In quality assessment models, different approaches are utilized to figure out the suitability of goals. In this context, SMART is a commonly used formulation in quality management. SMART denotes the applicability of quality objectives, and each letter stands for *specific*, *measurable*, *attainable*, *realistic*, and *timely*, respectively. According to this approach, any goal subjected to quality measurement must meet these five criteria.[76] The first three criteria—the requirements of being specific, measurable, and attainable—can also be implemented to bioethics education to understand whether these

goals are practical. The fourth criterion of this model, realistic examines "whether the objective is realistically applicable to the people responsible for performing the task," and the fifth criterion requires a specified time to accomplish the goal.[77] Nevertheless, as Harvey and Green accentuate, "[e]ducation is not a service for a customer but an ongoing process of transformation of the participant."[78] Therefore, it is thought that the criteria of being realistic and timely do not entirely suit bioethics education. However, specificity, measurability, and attainability can successfully be applied to the four goals. Nonetheless, this issue will be evaluated implicitly in the fourth section of this chapter when exploring quality standards and indicators of bioethics teaching. In other words, formulating certain standards and indicators would indirectly prove the presence of these characteristics.

6.3.3 Who is the Customer?

Identifying the customer is not only essential in education or bioethics education, but also in business, manufacturing, and marketing. In terms of business-related fields, the importance of accurately determining the customer is twofold: first, it is the customer who ultimately pays for the product or service; second, it is the customer's expectations, requirements, and satisfaction that shape the feature of the product or service and prompt the product or service development.[79] According to J. M. Juran, there is not a customer, but many customers, and "[o]ne of the basic methods for identifying customers is to follow the product to see whom it impacts. Anyone who is impacted is a customer," such as clients who buy the product, ultimate users who are the final users of the product, and regulators who impose rules on the product.[80] However, Donald C. Gause and Gerald M. Weinberg define individuals who are "affected by, or affect" a product as users. They describe customers as individuals who pay for the product or individuals who choose the

product. If the parent chooses a toy for the child and pays for the toy, the parent would be both the customer and user, while the child would only be the user. If the child chooses the toy and the parent pays for it, in this situation, both the child and parent would be the customers as well as the users (payers are always users because the payment affects their bank accounts).[81] In these two views, it is seen that Juran appraises the concept of *customer* in a broad sense covering all stakeholders of the product or service, while Gause and Weinberg reflect a narrow understanding of the term *customer* by limiting it to individuals paying for or choosing the product or services.

In regard to quality in healthcare, Avedis Donabedian uses the term *consumers* instead of *customers*. He considers the consumers' role in describing quality and determining quality standards to be indispensable.[82] Donabedian recognizes consumers as "coproducers of care," "vehicles of control," and "reformers of health care" in quality assurance.[83] He opposes describing practitioners as care providers and patients as care receivers. Donabedian asserts that healthcare is a production illustrating the cooperation of both parties, not only the practitioners' endeavor. Additionally, the weight of consumers in controlling healthcare organizations is another substantial point when acknowledging the consumers' role in quality assurance. According to Donabedian, consumers also have a position functioning as reformers by directly participating in care decisions; taking active roles in the administrative processes of forging quality-related notions; influencing healthcare markets; and having a certain impact on political actions.[84] In this view, it is possible to claim that consumers play a prominent role in defining quality and formulating quality standards in healthcare in accordance with their own expectations, perceptions, and needs.

Nevertheless, the main challenge in education is related to the question of whether any customer-based approaches should be applied to education, rather than how to identify the customer in education.[85] Education is not a tangible product or service that can be directly bought or sold; it is a dynamic and transformative process.[86] Paying for education does not change this reality. Therefore, instead of considering students or all stakeholders as customers, consumers, users, or clients, paying attention to the issue of learning and teaching would be more beneficial and more appropriate. In other words, the question should be who is learning or who is taught, not who is the customer. In the previous subsections, quality in bioethics education was defined as *conformance to the goals*, and four specific goals were determined: improving ethical knowledge; skills; behaviors; and cultural competence. From this perspective, the question is to whom does the knowledge, skills, behaviors, and cultural competence belong, and the answer is the learner. The learner is anyone participating in educational activities for the purpose of learning. On the other hand, as Henk ten Have underlines, quality in bioethics education could be appraised separately by the perspectives of the three dominant stakeholders of education: students, teachers, and institutions.[87] Such an approach may be necessary when students, teachers, and institutions have distinct goals. Nevertheless, in this chapter, as an assumption, it is considered that all these parties share and agree on the same goals.

As a result, it is believed that in the quality assessment of bioethics education, using the term *learner* and avoiding the word *customer* would more suitably and thoroughly reflect the nature of education. Additionally, it is important to emphasize that in this chapter the word *learner* mainly represents individuals in postsecondary education. Even though *The Teaching of Bioethics* indicates teaching bioethics in

elementary and secondary schools, the applicability and feasibility of this goal are doubtful.[88] Of course, ethics can be taught and ought to be taught in primary and secondary educational levels, but bioethics is a specified field and targets a particular group of learners. Generalizing bioethics education with its many components to all educational levels may be unrealistic. Thus, although *Bioethics for Every Generation* also concentrates on primary and secondary schools, during evaluating education in these schools, it mostly uses the term *ethics education*, rather than *bioethics education*.[89] In this context of this chapter, the learner refers to any individual in postsecondary and higher education learning bioethics.

6.4 Understanding the Framework

The manufacturing and business industry utilizes several approaches to increase satisfaction and productivity, reduce costs, and eradicate errors and waste. To ensure these objectives, different methodologies are used, one of which is DMAIC. The acronym DMAIC stands for *define*, *measure*, *analyze*, *improve*, and *control*.[90] Any quality assessment and improvement initiative requires similar methodologies. Rather than quality improvement, this chapter focuses on quality assessment. Therefore, the first two components of DMAIC, define and measure, are applicable to this present chapter. In the previous section, the relevant concepts were clarified and defined. As the second step, measurement criteria must be established. In this section, measurement methodologies will be examined to ascertain appropriate benchmarks to assess quality in bioethics education.

6.4.1 Three Approaches: Structure, Process, and Outcome

J. M. Juran recognizes quality planning as a process of quality management and states that "the quality-planning process can be generalized into one coherent, universal series of input-output steps," which consist of input, process, and output.[91] Juran deems input, process, and output as three elements of the input-output diagram and applies it to every step of quality planning. In respect to practice, in the case of exploring customers' needs, the list of customers is the input, the activity of discovering customers' needs is the process, and the consequence of this activity (detecting the needs) is the output.[92] The quality planning process is not the only area where the trio of input, process, and outcome is implemented. For instance, the SIPOC (*suppliers*, *inputs*, *process*, *outputs*, and *customers*) process map in Six Sigma is another example of using the input, process, and output set.[93] The trio of input, process, and output simply refers to the transformation of inputs into outputs through a process; hence, any activity receiving any input can be explained by this approach.[94]

Avedis Donabedian adapts the manufacturing-originated input, process, and output model to healthcare as structure, process, and outcome measures to assess quality in healthcare.[95] However, according to A. F. Al-Assaf, it is even possible to encounter early examples of structure, process, and outcome measurement models in healthcare.[96] For instance, in 1859, Florence Nightingale benefited from outcome measures to appraise the quality of healthcare services. Similarly, in 1910, Abraham Flexner's report, *Medical Education in the United States and Canada*, evaluated education in medical school in light of structure measures.[97] Even though the examples mentioned may indicate the utilization of some outcome and structure measures, it is difficult to accept them as early

examples of the Donabedian model because each of them displays only one component of the model. Donabedian regards structure, process, and outcome measures as equally crucial and complementary approaches to systematically and comprehensively assess the quality of healthcare services.[98] Nevertheless, it is essential to highlight that, contrary to the manufacturing-based input, process, and output steps, each of which is a necessary component of the whole, the Donabedian model encompasses three different approaches: structure, process, and outcome. Therefore, any of these approaches can be used independently of the other two when evaluating quality in healthcare. However, due to certain advantages and limitations of each approach, Donabedian concludes that "the best course of action is to use a combination of approaches" in order to "obtain a more complete assessment of quality" and "identify the causes of failures."[99] In other words, the Donabedian model originally comprises three approaches, which can either be employed separately or together, but it is suggested that they should be handled collectively so as to generate more accurate, thorough, and reliable quality assessment results. Furthermore, the hypotheses acknowledging an "interrelationship among structure, process, and outcome" request a collaboration of these three paradigms.[100]

Donabedian's structure, process, and outcome formulation is the most commonly used and most broadly accepted quality measurement model in healthcare.[101] The first element of the model, the structure, contains three items: material resources like physical equipment and facilities; human resources as the number and qualification of personnel; and organizational structure and administrative features "such as the organization of medical and nursing staffs, the presence of teaching and research functions."[102] The implementation of the structure relies on two assumptions. The first assumption is that

deploying appropriate material and human resources with a proper organizational structure will result in quality healthcare services. The second assumption is that the organization knows what good staff qualifications are as well as material and administrative characteristics.[103] These assumptions mean that if good inputs or ingredients are chosen and employed, then naturally desirable outcomes will follow. If structural necessities are overlooked, poor consequences will eventually be unavoidable.[104] According to Donabedian, the main advantage of structure-based measurement is to access the information used by this approach, but the relationship between the structure and the other two approaches is its main disadvantage.[105] It is obvious that without a well-functioning process, favorable inputs cannot create favorable outcomes, which means that the achievement of the structure also depends on the process.

The second approach—process—represents the activities of an organization to fulfill its objectives. In healthcare, prevention, treatment, rehabilitation, and education are major activities, and performing these functions denotes the process.[106] Donabedian deems the process as "the most direct approach" for measuring the quality of care a patient receives because it shows caregivers' performance.[107] The process is the stage where and when all the components of the structure are taken into action to produce desirable outcomes. Looking at the effectiveness of a procedure, the process cannot be applied because it does not concentrate on the quality of the procedure, but on the practice of the procedure.[108] For example, in the case of requesting an X-ray screening, the process examines whether the screening is properly performed by the pertinent department, not whether the screening is an effective way to diagnose disease; the issue

of effectiveness is relevant to the outcome, not the process. In this case, checking all procedures to figure out which of them are carried out is an essential feature of the process. Additionally, the possibility of providing real-time information is another advantage of the process.[109] These situations do not make the process free from certain limitations, such as relying on assumptions concerning what good practices are.[110] For instance, without investigating the outcomes, it is impossible to know whether prescribing a medication is an effective treatment.

The outcome is the most frequently utilized approach in quality evaluation of healthcare by measuring the consequences of care on individuals and populations, like mortality and morbidity.[111] The outcome refers to "the integrated and cumulative effect of the entire range of health activities."[112] In other words, outcomes do not merely illustrate the final results of each procedure and action, but also display the totality of all inputs, procedures, and actions conducted. In this context, the outcome gives final and concrete information about the whole process of care. Therefore, the validity and reliability of outcomes is the principal advantage of this approach. Nevertheless, attributing all the virtues of good consequences or the responsibility of undesirable results to the quality of care is an inaccurate assessment. Health-related outcomes are also shaped by numerous external factors including; life-style, age, and sex; as well as social, economic, and environmental determinants.[113] Moreover, when appraising outcomes, "focus[ing] on aggregate data rather than on individual or case-by-case analysis limits its usefulness" for individuals or individual cases.[114] However, it should be acknowledged that experiencing some deviations is possible in the case of the other approaches as well.

In light of these clarifications, the structure, process, and outcome approaches can also be considered useful and practical methods to measure quality in bioethics education. To avoid the disadvantages and shortcomings of each approach, an integrated model can be utilized to benefit from the advantages of each of them. Furthermore, due to the primary attribute of education as a transformative process, taking all three stages (structure, process, and outcome) into account is more beneficial for seeing and projecting the whole picture. For example, merely revolving around outcomes, without evaluating the quality of structures and processes, would cause short-sightedness in the long-term consequences. In education, favorable outcomes alone cannot prove the effectiveness of structures or processes. Similarly, unfavorable outcomes cannot directly indicate the failure of a structure and process because there are always some other factors positively or negatively influencing outcomes.[115] It is possible to encounter students performing well or poorly in the same school or even in the same class. For this reason, the quality of education not only depends on the structure, process, or outcome, but also includes several external elements, such as the socioeconomic environment students come from. However, the purpose of measuring quality in bioethics education is to assess the overall situation of a bioethics program or course, rather than evaluating the performance of each student separately. In this context, it is believed that quality is the combination of a well-designed structure, effective processes, and favorable outcomes.

In this chapter, the outcome refers to the goals of bioethics education (increasing ethical knowledge, improving ethical skills, developing ethical behavior, and promoting cultural competence), which are also four essential expected outcomes. The outcome measures gauge whether the predetermined goals are accomplished. Furthermore, the

learner's satisfaction should also be regarded as an outcome because satisfaction is an essential requirement to ensure the survival of a program or institution.[116] In other words, even though satisfying the learner's expectations is not a primary goal of bioethics education, devoting sufficient attention to the learner's needs, expectations, and satisfaction is a central outcome regarding quality assessment. Thus, many sources define quality as customer satisfaction or "meeting or exceeding customer expectations."[117] Regardless of the quality of the structure, process, or outcome, a lack of the learner's satisfaction may lead to the termination of a program or course. From this perspective, in this chapter, besides the four goals, the learner's satisfaction will also be accepted as an expected outcome.

In respect to bioethics teaching, the structure comprises the following inputs: curriculum; human resources; material inputs; physical facilities; and technological facilities. These inputs must be used in harmony to realize the expected outcomes. The presence or absence of these elements would not generate any outcome per se, but as a presumption, it is assumed that quality inputs would bring about quality outcomes. Nevertheless, as Donabedian accentuates, "staff qualifications, physical structure, and formal organization are not equated with quality."[118] The crucial challenge of the structure is to decide what the quality inputs are. Additionally, to some extent, any formulated standard or indicator regarding the structure will contain subjective judgments. However, their effectiveness may be validated through long-term observation, measurement, and analysis. In this view, as a normative approach, the present chapter deems the abovementioned five inputs to be main categories of the structure through a literature-based perspective.

As Ray Tricker and Bruce Sherring-Lucas underline, the process is a dynamic level transforming the inputs of structure into outcomes.[119] Any defect of the process may directly weaken the effectiveness of the relationship between the structure and outcomes. For this reason, processes should be comprehensive, applicable, and productive to convert inputs into the desired outputs. Similar to the assumptions regarding the structure, the process relies on some expectations that proper processes would engender a fruitful connection between inputs and outcomes. Moreover, the process is the most difficult area for which to determine measurement criteria; they must not only be potent, but also specific, measurable, and attainable. Furthermore, they could be considered subjective as long as adequate research studies do not validate their productivity.

Besides all these challenges, another problem is how to distinguish the structure from the process and the process from the outcome.[120] Nonetheless, the structure and outcome denote static situations; the former shows inputs and the latter indicates outputs, while the process represents dynamic courses of action. In this view, the structure and outcome only evaluate the presence or absence of these static situations, whereas the process assesses the function of relevant dynamic courses of action. For instance, when empowering learners to explore their potential, the instructor, student, and physical environment become the elements of the structure; granting the student freedom and authority addresses the process; and the matter of whether the student has developed self-confidence and self-actualization represents the outcome. Additionally, by determining standards and indicators in the next section, the distinction among these three items will become more evident.

6.4.2 Standards and Indicators

The structure, process, and outcome approaches only demonstrate areas of quality measurement in bioethics education. Evaluating the attributes of these areas requires implementing particular benchmarks to obtain concrete results. Different sources utilize different terms including *criteria*, *measures*, *standards*, and *indicators* as meter sticks to pinpoint the quality of measured points. For instance, Six Sigma uses the terms *measures* and *indicators* to point out the performance of activities.[121] Donabedian employs criteria and standards to gauge healthcare service performances.[122] In the United States, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), also known as the Joint Commission, applies standards and indicators to make quality assessment of healthcare institutions.[123] Similarly, in the United Kingdom, the National Institute for Health and Care Excellence (NICE) utilizes standards and indicators to guide and measure quality in healthcare organizations.[124] Educational organizations, such as the South Carolina Department of Education, also develop and implement standards and indicators (or performance indicators) to figure out the effectiveness of their programs.[125]

Nevertheless, even though all these terms intend to assess the quality of products, services, or processes, the conceptual meaning of a term in one text/area may differ from the same term in another text/area. In other words, the terms *standard* and *indicator* do not refer to the same connotation in all sources. Donabedian describes the term *standard* in healthcare as "a specified quantitative measure of magnitude or frequency that specifies what is good or less so," like requesting at least one registered nurse for every two occupied beds at an intensive care unit.[126] On the other hand, Mick Zais defines the term *standard* in education as "[s]tatements of the most important, consensually

determined expectations for student learning in a particular discipline," such as the standard for a kindergarten student in life science to "demonstrate an understanding of organisms found in the environment."[127] The former denotes an exact quantitative criterion that is directly subject to measurement, while the latter addresses a more general requirement without involving a precise measurement criterion. Donabedian's definition of *standard* goes by the term *indicator* in many other texts. For instance, James R. Evans and William M. Lindsay explain *indicators* as numerical information indicating "measurements that are not a direct or exclusive measure performance" (e.g. the number of complaints to measure dissatisfaction).[128] Similarly, Eleanor Gilpatrick describes the term *indicator* in healthcare as "[a] quantitative measure of an aspect of care" when expounding *standards* as "[e]xpectations or requirements against which current or future performance is measured."[129] In this view, it can be stated that both standards and indicators are means to measure quality. However, indicators are more specific than standards because indicators refer to ultimate measurability.[130]

In the quality assessment of products and some services, like certain clinical practices, quantitative analyses are largely possible thanks to the availability of numeric information and data. In such areas, indicators can be defined in a numerical manner. However, for many aspects of educational activities, it is very difficult to express the inputs, processes, or outputs through quantitative information. For this reason, in general, even though indicators represent evaluative numerical data, in bioethics education, indicators should perhaps be described using qualitative benchmarks without the necessity of requesting quantitative measures. Of course, the presence of numerical information presents a favorable situation because it carries the potential for more

objective and verifiable results. Nevertheless, the nature of education does not always lend itself to quantitative measures. For instance, in the case of having a standard, such as to "[p]rovide students with challenging learning experiences," it may be almost impossible to formulate indicators that measure this expectation with quantitative information.[131] The number of students who are exposed to this experience would most likely comprise the only numerical data because there would be no way to determine a precise measurement of how much of the experience each student receives.

From this perspective, in this chapter, *standards* represent certain general requirements or expectations regarding the attributes of the structure, process, and outcome to measure quality in these areas. *Indicators* denote the transformation of the standards into specific and measurable criteria. As Gilpatrick underscores, "[s]tandards and indicators complement each other"; both function to achieve the same goal: assessing quality.[132] Nevertheless, indicators are more specific than standards and are derived from standards to codify measurable criteria. For instance, a structure-based standard, *the teacher is qualified*, shows the requirement for the characteristics of the instructor. Although this requirement necessitates the availability of some qualifications, the standard does not specify how to decide whether the instructor is qualified. To clarify this ambiguity and provide the opportunity to measure this standard, at least one indicator must be formed to address the measurability of the standard. In this sense, certain indicators, such as *the teacher has at least a master's degree in bioethics* and *the teacher has teaching experience* must be forged. The presence or absence of a master's degree and teaching experience, which may also be expressed as a specific number of years of experience, will be the measurable benchmarks of the standard.

Another crucial question concerning standards and indicators is how they can be formulated. According to Donabedian, they are derived from empirical and normative knowledge. Empirical standards stem from existing practices, while normative standards come from theoretical ideas and perspectives.[133] In other words, empirical standards come "from patterns of care observed in actual practice," while normative standards "derive from what is declared to be "good" by persons or groups recognized as legitimate authoritative sources of knowledge."[134] Rather than benefiting from only one of them, maybe the most appropriate way is to integrate empirical knowledge into normative knowledge. Additionally, legal regulations, past experiences, public expectations, and institutional policies can also be taken into consideration during this integration.[135] However, the present chapter relies on normative knowledge to determine quality standards and indicators for bioethics education. Different quality related sources in education highlight various aspects, needs, and expectations of distinct stakeholders. Through a normative and integrative approach, these differences will be consolidated to establish particular criteria for the structure, process, and outcome measures.

6.5 Formulating Standards and Indicators

Education is an open-ended phenomenon, in respect to its outputs and processes. This situation may lead different parties to emphasize distinct requirements and expectations. Students, teachers, and institutions providing the education are major players in education with different perspectives.[136] Quality assessments can be made for each of these parties separately. Nevertheless, the approach of this chapter concerning quality measurement is grounded on the abovementioned goals of teaching bioethics and definition of quality in bioethics education. This approach reflects the assumption that the

goals and definition represent common aims and expectations on which all parties agree. In this context, the suggested quality standards and indicators will refer to a common perspective of all the main stakeholders without focusing on any parties' specific needs or expectations. Furthermore, the proposed standards and indicators will be the product of the first attempt to specify measurable criteria for bioethics education through a normative perspective. For this reason, these formulated standards and indicators can be subject to additions, modifications, or deductions in accordance with new approaches, emerging challenges in practices, or evidence of their ineffectiveness. The proposed standards and indicators will be listed in the appendix at the end of the chapter. In the following sub-sections, a general approach to the formulation of the standards and indicators will be depicted.

6.5.1 Structure-Based Standards and Indicators

Curriculum, human resources, physical materials, physical facilities, and technological accommodations constitute essential dimensions of the structure. It is presumed that quality in these areas would influence the quality of education; better inputs would accomplish higher quality outcomes. In this view, curriculum is an essential determinant of quality education.[137] The decisions concerning whether or not to have a bioethics course, whether the course should be required or elective, the goals, content, teaching method, length, and place of the course are shaped by the curriculum. According to the Commission on the Teaching of Bioethics, "[c]urricula should consist of courses designated to teach how to identify, define, argue, and work toward a resolution of ethical issues … [and] must have sufficient length and continuity to expose in an ordered way the lines of reasoning contributing to those activities."[138] However, studies show that one

of the main challenges in teaching ethics is the lack of a comprehensive, well-organized, and applicable curriculum.[139] UNESCO's *Bioethics Core Curriculum* is a significant source to meet this need and guide institutions to generate their own curricula in accordance with their own needs and missions. Even though it is difficult to find a consensus on curriculum related issues in the literature and among the practices of different institutions, in order to achieve an effective bioethics education, a curriculum satisfying the goals, expectations, and needs of a program should be available.

The second component of the structure is human resources. Teachers and learners are the two fundamental elements of human resources in education. Of course, administrative and other personnel are also part of human resources, but it is mainly teachers and learners who are directly experiencing educational processes.[140] From this perspective, the teacher is the most prominent player in constructing an effective learning environment. It is a common maxim that "[q]uality education is delivered by good teachers."[141] Nevertheless, the crucial question is who is a good teacher or which characteristics make them a good teacher. Daniel Callahan clarifies this matter by questioning whether a graduate degree in bioethics proves the qualification of a teacher.[142] Callahan accentuates five problems with acknowledging a degree as an adequate requirement for teaching bioethics. Firstly, it is possible to encounter good teachers who do not have a formal ethics degree. Secondly, teaching ethics necessitates possessing a wide range of knowledge about other pertinent fields as well. Thirdly, effective ethics teaching does not only depend on the teacher's knowledge, but also their relevant experience in the field. Fourthly, personal attributes and pedagogical skills may

sometimes be more essential than a formal degree. Finally, another challenge is how to perceive ethics; whether from a religious or philosophical perspective.[143]

Each of the matters underlined by Callahan demonstrates a critical argument regarding different aspects of ethics education and qualifications of teachers. However, as an element of the structure measures, teacher qualifications should be determined by tangible benchmarks, one of which is a degree in bioethics. Additionally, the teacher's teaching experience and academic engagements should also be appraised as part of the structure measures. It is important to highlight that the availability of a degree, experience, and academic credentials would not deem the teacher as a good teacher in terms of the overall assessment, but only in the structural evaluation. The teacher's performance during educational processes, and their ability to transform these qualifications into favorable outcomes through appropriate processes would eventually verify whether they are a good teacher or not.

The learner is the second decisive component of human resources in the structure measures. Like the qualifications of teachers, the learner may need certain qualities as well, at least for some level of bioethics education.[144] Nevertheless, in many cases, the learner is already a participant of a program, and it may not be meaningful to ask for specific qualifications to take a bioethics course. Rather than the learner's pre-admission exam results, the learner's interest in bioethics is a noteworthy matter in achieving desired outcomes of bioethics teaching. Attracting learners' interest is mostly considered a task for teachers, and teachers are encouraged to explore and apply appropriate methods to motivate learners.[145] However, the author's experience indicates that regardless of the teacher's effort to make the teaching more attractive and interesting, the learner's interest

is a significant factor, especially when bioethics education is provided as a required course for future healthcare professionals like medical and nursing students. Some students from these schools, including even some healthcare professionals who already practice their professions, may believe that becoming a good healthcare professional does not require taking a bioethics course because their primary duty is to focus directly on the knowledge of medicine, which, unlike academic ethics, diagnoses and cures diseases. T. B. Brewin reflects this view by stating that "[t]he most caring doctor may be totally ignorant of academic ethics… Has anyone ever said about a friend or neighbor that the reason he is so thoughtful and kind is that he has studied ethics?"[146] Moreover, this perception may become even more apparent when a bioethics course is taught by a teacher who does not have a medical background.[147] Under such a prejudiced circumstance, despite the teacher's high qualifications and concerted efforts, the outcomes may be fruitless because "the teacher can teach only what the student can hear."[148] Therefore, the learner's interest in learning bioethics should be regarded as a major requirement of structural measures.

Physical materials, physical facilities, and technological accommodations are other major categories of the structure. Physical materials refer to the syllabus, textbooks, and other teaching materials including classroom equipment, such as computers and projectors. A well-organized syllabus, up-to-date and proper teaching materials, as well as sufficient and purposeful equipment are complementary instruments of quality education.[149] Similarly, physical facilities such as the classroom and library are supplemental components to attaining productive outputs.[150] In particular, in the case of graduate level bioethics education, the presence of a library and the types of library

services available may play a central role in academic achievement. Furthermore, technological developments have led to Internet-driven opportunities becoming indispensable facilities in education. For instance, even though a physical classroom and library are significant, because of today's technological opportunities, it is almost necessary to provide e-library and e-classroom options. It is expected that the learner should be able to access library resources without needing to go to the library. Additionally, even in the case of an in-classroom teaching model, distance learners should be able to follow the classes through real-time e-classroom facilities. As a result, physical materials and facilities should be supported by online opportunities as much as possible to facilitate access to bioethics education and pertinent resources.

6.5.2 Process-Based Standards and Indicators

Process measures are the most difficult and contentious components in the quality assessment of bioethics education due to the subjectivity of the processes. It does not matter how many processes there are or how they are formulated, their quantity and quality will reflect a particular view which may be criticized by some. In light of the acceptance of this limitation, the general approach of this chapter may be summarized by drawing an analogy with distinctions between a leader and manager in business in order to illuminate the teacher's role in teaching bioethics. Differentiating attributes and skills of a leader from a manager is a long-standing discussion. Nevertheless, it is possible to underscore the main characteristics of a leader, through the different definitions elaborated by Kathryn S. Hoff, as motivating, influencing, building, aiming to change, and doing the right things, while the corresponding traits of a manager can be underlined as organizing, planning, controlling, aiming to maintain, and doing things right.[151] In this

context, in both the teaching process and relationship with learners, a bioethics teacher should be a leader or demonstrate the attributes of a leader rather than a manager.[152] The goals of bioethics education should be accomplished through an all-inclusive and critical thinking-oriented teaching approach which should motivate, inspire, and empower learners. As mentioned by the classical maxim, learners should be taught how to fish, not given fish.

Effective communication between the teacher and learners is the first condition to create a positive learning environment.[153] The teacher should show an attitude of active listening to make learners feel that he/she understands their needs and is ready to help them.[154] Clarifying the aim, methodology, and expectations of the course by a well-formed syllabus and hearing about the needs and expectations of learners is an essential starting point of ethics teaching. Ronald R. Sims explains this process as a "psychological contract" which is "a set of unwritten reciprocal expectations between the student and [the teacher]."[155] Therefore, the first category of the standards and relevant indicators in the process should concentrate on establishing trustful communication and clear expectations.

Increasing learners' knowledge and improving their pertinent skills are major purposes of education. For this reason, learners should acquire relevant bioethics knowledge and skills through appropriate tools, proper content, and approachable teaching methods. Nevertheless, the central problem is how to decide what these tools, content, and methods are. The literature emphasizes lectures with audio-visual aids, group discussions, real-life case analyses, short videos, role-playing, and student presentations.[156] It is thought that due to several merits of each of these methods, having

a bioethics course benefiting from all these means may be the most beneficial way. In this view, teaching method-based process measures should look for the availability of all the above-mentioned tools. The content of teaching, which refers to the question of what to teach, is another challenge in bioethics education, whether teaching about moral theories, ethical principles, professional ethics codes, and controversial subjects such as abortion and euthanasia.[157] Albert R. Jonsen is in favor of not offering any lecture directly delineating ethical theories and principles in medical ethics on the grounds of the idea that they can be "grasped by students in and through case analysis rather than from speculative presentations."[158] On the other hand, Robert M. Arnold and his colleagues assert that "[e]thical theory is best taught, not for its own sake, but as an analytical tool to help resolve clinical problems."[159] Similarly, the Commission on the Teaching of Bioethics embraces the teaching of normative theories and various topics including polemical subjects like abortion.[160] Bioethics education aims to deepen ethical knowledge and enhance ethical skills to raise ethical sensitivity, awareness, and judgment through a critical thinking perspective. It is believed that such an extensive goal cannot be attained without teaching moral theories. For building a concrete ethical base, moral theories and ethical principles should be taught prior to evaluating controversial ethical subjects.

Determining the manner of teaching, or teaching approach, is as important as teaching tools and content. As accentuated above, a bioethics teacher should carry or demonstrate the attributes of a leader, which requires becoming a facilitator by empowering, encouraging, and guiding learners to express themselves and supporting, respecting, and appreciating learners' thoughts, views, and concerns. Ann M. Begley defines teaching ethics as "facilitating the acquisition of theoretical wisdom."[161]

According to Lee Harvey and Diana Green, enhancing and empowering learners are the imperative elements of quality in education when quality is described as an ongoing transformative process.[162] UNESCO *EFA Global Monitoring Report* counts encouraging learners and their creativity as a central function of education.[163] Ronald R. Sims states that establishing "a safe and trusting environment where students are willing to share their experiences is essential for the depth of personal learning."[164] In this context, bioethics education should promote the ethical transformation of learners without imposing any particular belief on them, but by identifying, recognizing, and respecting social, cultural, and religious differences. "[T]oday's "right solution" [may turn into] tomorrow's dogma."[165] Therefore, teaching approach-related standards and indicators should be formulated around these stances.

Furthermore, almost all bioethics teaching courses necessitate an evaluation, in terms of grading learners. Timely and fair grading and assessment is central to fulfill learner satisfaction.[166] Moreover, a good teacher should be a good observer, not only to identify and understand learners' needs, expectations, and concerns, but also to observe learners' reactions to existing teaching tools, content, and approaches in order to evaluate their effectiveness. The teacher's observation can be merged with learners' feedback to modify the syllabus and curriculum.[167] For this reason, addressing these two issues in the process measures may also be beneficial in quality assessment.

6.5.3 Outcome-Based Standards and Indicators

In contrast to the process measures, determining outcome standards and indicators is not as challenging because they chiefly denote the goals of education. Thus, UNESCO *EFA Global Monitoring Report* underscores that "[t]he outcomes of education should be

assessed in the context of its agreed objectives."[168] In this sense, bioethics education has four goals: increasing ethical knowledge; improving ethical skills; developing ethical behavior; and promoting cultural competence.[169] In the second section of the present chapter, these goals were examined in detail. To avoid duplication, the meaning and content of these goals will not be elaborated any further. However, it may be helpful to reiterate that learners' satisfaction was added to these four goals as the fifth benchmark of the outcome measures. In other words, the outcome standards and indicators should portray five expectations: improvements in learners' ethical knowledge, ethical skills, ethical behavior, cultural competence, and satisfaction.

Nevertheless, listing these expectations does not make the outcome standards and indicators unproblematic; the measurability or measurement method of these indicators may be puzzling. This challenge can also be seen when assessing the process standards and indicators. However, when evaluating the process measures, a learner-oriented questionnaire could be useful to figure out whether the proposed processes are being conducted. Nevertheless, gauging some expected outcomes, such as developing ethical behavior may cause some difficulties. For instance, an examination, teacher evaluation, or learner self-assessment might provide certain clues concerning the learner's knowledge, skills, cultural competence, and satisfaction (evaluating learners' skills and cultural competence may require specific tasks, like case analyses and observing them when they practice their profession). Nonetheless, deciding whether the learner has gained any behavioral improvement may require long-term observation and assessment which could exceed the course's teaching period. According to Michael D. Mumford and his colleagues, "reduction in the rates of fabrication, falsification, and plagiarism" can be

used as a behavioral measure in ethics programs.[170] In the case of a bioethics program with a long teaching period, the suggestions mentioned might be meaningful to detect behavioral changes, but during a four-month course, it may be very difficult to observe any shift in the learner's behavior. Nevertheless, it is believed that experiencing this difficulty does not prevent having such a purpose in teaching bioethics.

6.6 Conclusion

This chapter aims to formulate specific, measurable, and attainable standards and indicators to gauge the quality of bioethics programs. Quality in bioethics education is defined as *conformance to the goals*. The goals refer to: increasing the learner's ethical knowledge; improving the learner's ethical skills to strengthen his/her ethical sensitivity, awareness, and judgment; developing the learner's ethical behavior; and promoting the learner's cultural competence. Donabedian's three approaches—structure, process, and outcome—are utilized to demonstrate the major quality assessment categories. *Standards* denote certain general requirements or expectations regarding the attributes of the structure, process, and outcome to evaluate quality in these areas. *Indicators* represent the transformation of the standards into specific and measurable criteria. The structure-based standards and indicators are classified as curriculum, human resources, physical materials, physical facilities, and technological accommodations. The process-based standards and indicators are categorized as communication, teaching methods, teaching scope, teaching approach, evaluation, and observation and modification. The outcome-based standards and indicators are classified as ethical knowledge, ethical skills, ethical behavior, cultural competence, and satisfaction. All the suggested standards and indicators are listed in the appendix. This chapter represents a perspective which is all-

inclusive, but also normative. For this reason, specific needs, concerns, and practices may require certain changes in these proposed standards and indicators. In the case of a research study, the researcher can modify these standards and indicators in accordance with the research design.

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Appendix

Quality Standards and Indicators

Quality: Conformance to the goals.

Goals: 1. Increasing ethical knowledge,

2. Improving ethical skills to strengthen ethical sensitivity, awareness, and judgment,

3. Developing ethical behavior,

4. Promoting cultural competence.

Three Measurement Categories:

A- Structure Measures	B- Process Measures	C- Outcome Measures
1. Curriculum	1. Communication	1. Ethical Knowledge
2. Human Resources	2. Teaching Method	2. Ethical Skills
3. Physical Materials	3. Teaching Scope	3. Ethical Behaviors
4. Physical Facilities	4. Teaching Approach	4. Cultural Competence
5. Technological Accommodations	5. Evaluation	5. Satisfaction
	6. Observation and Modification	

Standards and Indicators

The structure, process, and outcome standards and indicators are listed separately. The code with one digit shows main categories, two-digits indicates sub-categories, three

digits demonstrates standards, and three digits plus a letter illustrates indicators. For example;

1. Main Category

1.1 Sub-category

1.1.1 Standard

1.1.1a Indicator

A- STRUCTURE

Code	Standard-Indicator
S1	**Curriculum Standards**
S1.1	**Curriculum-Based Standards**
S1.1.1	**The curriculum is available**
S1.1.1a	The curriculum exists
S1.1.1b	The curriculum is accessible by teachers
S1.1.2	**The curriculum elaborates bioethics education**
S1.1.2a	The curriculum directly addresses the teaching of bioethics
S1.1.3	**The curriculum is comprehensive and well-organized**
S1.1.3a	The curriculum demonstrates the goals of bioethics teaching
S1.1.3b	The curriculum indicates the teaching methods of bioethics education
S1.1.3c	The curriculum illustrates the teaching approach of bioethics education
S1.1.3d	The curriculum explains the content of teaching bioethics

S1.1.3e	The curriculum points out evaluation methods
S1.1.3f	The curriculum shows the maximum number of learners in a classroom
S1.1.3g	The curriculum displays when/which year bioethics will be taught
S1.1.3h	The curriculum explains whether bioethics education will be provided as a required, elective, separate, or integrated course.
S2	**Human Resources Standards**
S2.1	**Teacher-Based Standards**
S2.1.1	**The teacher is qualified**
S2.1.1a	The teacher has a relevant degree (at least a master's degree) in bioethics
S2.1.1b	The teacher has teaching experience
S2.1.1c	The teacher has relevant academic works (such as publications and conferences)
S2.1.2	**The teacher is interested in teaching bioethics**
S2.12a	The teacher likes teaching bioethics
S2.1.2b	The teacher does not miss classes
S2.1.2c	The teacher begins classes on time
S2.2	**Learner-Based Standards**
S2.2.1	**The learner is interested in learning bioethics**

S2.2.1a	The learner is willing to learn bioethics
S2.2.1b	Learner attends classes
S2.2.1c	Learner is in the classroom on time
S3	**Physical Material Standards**
S3.1	**Syllabus-Based Standards**
S3.1.1	**The syllabus is available**
S3.1.1a	The syllabus is prepared prior to starting classes
S3.1.1b	The syllabus is accessible by learner prior to starting classes
S3.1.2	**The syllabus is understandable and comprehensive**
S3.1.2a	The syllabus explains the aim of the course
S3.1.2b	The syllabus defines expectations
S3.1.2c	The syllabus shows learners' responsibilities
S3.1.2d	The syllabus demonstrates course materials and sources
S3.1.2e	The syllabus shows when and what will be taught
S3.1.2f	The syllabus indicates evaluation criteria
S3.1.2g	The syllabus elaborates the policy of the course
S3.1.2h	The syllabus explains how learners can contact the teacher
S3.2	**Teaching Materials-Based Standards**
S3.2.1	**Teaching materials (textbooks and other teaching materials) are accessible**
S3.2.1a	Learners know how they can access the teaching materials
S3.2.1b	Access to the teaching materials is affordable
S3.2.1c	Additional options to access the teaching materials is available

S4	**Physical Facilities Standards**
S4.1	**Classroom-Based Standards**
S4.1.1	**A classroom is available**
S4.1.1a	There is a physical classroom for use
S4.1.2	**The classroom has a convenient location**
S4.1.2a	The classroom is easily-accessible
S4.1.2b	The classroom is protected from external disturbances, such as noise
S4.1.3	**The physical conditions of the classroom are acceptable**
S4.1.3a	There is sufficient room for all learners
S4.1.3b	Classroom temperature and lightning is appropriate
S4.1.4	**The classroom is technologically well-equipped**
S4.1.4a	The required equipment such as a computer and projector is available
S4.2	**Library-Based Standards**
S4.2.1	**A library is available**
S4.2.1a	There is a library that learners can use
S4.2.2	**The physical conditions of the library are appropriate**
S4.2.2a	There are convenient areas in the library giving learners the opportunity to study
S4.2.3	**The library provides technical facilities**
S4.2.3a	The library allows learners to access a computer

S4.2.3b	The library provides Wi-Fi access
S4.2.3c	The library gives printing-out and scanning opportunities
S4.2.4	**The library has relevant resources (textbook, journal, video materials, etc.)**
S4.2.4a	The library has sufficient bioethics resources
S4.2.4b	The bioethics resources are easily accessible
S4.2.4c	Learners can borrow these resources for an appropriate period
S4.2.5	**The library supplies resources that are unavailable at the library**
S4.2.5a	The library can borrow the requested textbooks, journal articles, and so on from external sources
S4.2.5b	The library supplies these resources in a reasonable period
S4.2.5c	The library does not charge learners for these services
S5	**Technological Accommodations**
S5.1	**E-Library-Based Standard**
S5.1.1	**E-Library services are available**
S5.1.1a	Learners can access the library services via the website
S5.1.1b	E-Library services are offered free of charge
S5.1.2	**E-Library services are user-friendly**
S5.1.2a	Access to e-Library services is simple
S5.1.2b	Learners can download online resources
S5.1.2c	Learners can access the resources they need online
S5.2	**Online Classroom-Based Standards**

S5.2.1	**The online classroom opportunity is available**
S5.2.1a	Learners are given the chance to follow classes when they are in distance learning
S5.2.2	**The online classroom system is user-friendly and convenient**
S5.2.2a	Learner can easily access the online classroom
S5.2.2b	The online classroom allows learners to see and hear the teacher
S5.2.2c	The online classroom allows the teacher and learners in the classroom to see and hear the distance learner
S5.2.2d	The online classroom allows the distance learner to follow the classroom presentations
S5.2.2e	The online classroom allows the distance learner to present her/his presentation

B- PROCESS

Code	Standard-Indicator
P1	**Communication Standards**
P1.1	**Communication-Based Standards**
P1.1.1	**The teacher demonstrates the willingness to build an effective communication with learners**
P1.1.1a	The teacher listens to learners about their needs, concerns, and expectations

P1.1.1b	The teacher shows sufficient effort to understand learners needs, concerns, and expectations
P1.1.1c	The teacher has adequate empathy with learners regarding their needs, concerns, and expectations
P1.1.1d	The teacher responds positively to learners' reasonable requests
P1.1.2	**Learners demonstrate readiness to establish a good relationship with the teacher**
P1.1.2a	Learners make sufficient effort to understand the goals of the course and the teacher's expectations
P1.1.2b	Learners expressly explain their needs, concerns, and expectations
P1.1.2c	Learners know their reasonable requests will be responded to positively
P1.1.3	**The teacher applies an open-door policy**
P1.1.3a	The teacher is physically available for certain times every week
P1.1.3b	The teacher gives learners the change to express their individual questions, needs, or concerns before and after classes
P1.1.3c	In the case of email-based communication, the teacher responds to emails in a timely manner.
P1.2	**Expectations-Based Standards**
P1.2.1	**The teacher clarifies all issues the syllabus encompasses in the first class**
P1.2.1a	The teacher specifies the aims of the course
P1.2.1b	The teacher explains the methodology of the course

P1.2.1c	The teacher clearly expresses course expectations
P1.2.1d	The teacher points out the course materials
P1.2.1e	The teacher clarifies how learners can access the course materials
P1.2.1f	The teacher specifies the evaluation system and grading
P1.2.1g	The teacher addresses all relevant policies that will be followed during classes
P1.2.2	**The teacher ensures that learners understand the clarified issues**
P1.2.2a	The teacher asks learner whether they have any question about the matters explained by the syllabus
P1.2.2b	The teacher allows learners to freely express their comments, objections, and expectations about the course and syllabus
P1.2.3	**The teacher demonstrates readiness to modify the syllabus**
P1.2.3a	The teacher take reasonable comments and objections regarding the syllabus into consideration
P1.2.3b	The teacher modifies the syllabus in accordance with the agreement reached when assessing the syllabus
P2	**Teaching Method Standards**
P2.1	**Teaching Tools-Based Standards**
P2.1.1	**The teacher gives lectures**
P2.1.1a	The teacher has PowerPoint presentations
P2.1.1b	The teacher tries to attract learners' attention by asking questions during lectures
P2.1.1c	The teacher allows learners to ask questions during lectures

P2.1.1d	The teacher uses short videos during lectures
P2.1.1e	The teacher utilizes real-life cases
P2.1.1f	The teacher integrates relevant legal cases into lectures
P2.1.2	**The teacher uses group activities**
P2.1.2a	The teacher forms small discussion groups
P2.1.2b	The teacher uses role-play through learners' participations
P2.1.2c	The teacher provides cases to learners to discuss
P2.1.3	**The teacher gives learners certain assignments**
P2.1.3a	The teacher gives learners short reading assignments
P2.1.3b	The teacher gives learners writing assignments
P2.1.3c	The teacher gives learners case analysis-based assignments
P2.1.4	**Learners make presentations**
P2.1.4a	Each learner gives a presentation about a specific subject
P2.1.4b	Learners use PowerPoint presentations
P2.1.4c	Learners answer questions at the end of their presentations
P3	**Teaching Scope Standards**
P3.1	**Content-Based Standards**
P3.1.1	**The teacher teaches relevant concepts**
P3.1.1a	The teacher clarifies what ethics is
P3.1.1b	The teacher explains the distinctions between ethics, morality, and law
P3.1.1c	The teacher specifies the differences among bioethics, medical ethics, and other relevant disciplines

P3.1.1d	The teacher summarizes the emergence of bioethics
P3.1.2	**The teacher teaches moral theories**
P3.1.2a	The teacher teaches major moral theories like deontology, consequentialism, and virtue ethics
P3.1.2b	The teacher explains the primary differences among the moral theories
P3.1.2c	The teacher give specific examples indicating the implementation of the moral theories
P3.1.3	**The teacher teaches ethical principles**
P3.1.3a	The teacher defines ethical principles
P3.1.3b	The teacher clarifies the relationship between different principles
P3.1.3c	The teacher explains conflicts between different principles
P3.1.4	**The teacher teaches decision-making processes**
P3.1.4a	The teacher describes informed consent and its elements
P3.1.4b	The teacher specifies decision-making capacity and pertinent concepts
P3.1.4c	The teacher defines advance directives
P3.1.4d	The teacher explains surrogate decision-making procedures
P3.1.5	**The teacher provides learners information about controversial ethical issues like abortion and euthanasia**
P3.1.5a	The teacher specifies beginning-of-life issues
P3.1.5b	The teacher addresses end-of-life issues

P3.1.5c	The teacher provides all cultural, religious, and philosophical arguments about contentious issues
P4	**Teaching Approach Standards**
P4.1	**Teaching Manner-Based Standards**
P4.1.1	**Learners are given the opportunity to express their thoughts, views, and values**
P4.1.1a	The teacher encourages learners to express their thoughts, views, and values
P4.1.1b	The teacher respects learners' thoughts, views, and values
P4.1.1c	The teacher strives to understand why learners have different thoughts, views, and values
P4.1.2	**The teacher informs and guides learners**
P4.1.2a	The teacher gives information about different approaches to specific ethical issues
P4.1.2b	The teacher explains how different approaches can be applied to specific ethical issues
P4.1.2c	The teacher clarifies how learners can evaluate specific ethical issues in accordance with their own thoughts, views, and values.
P4.1.3	**Learners are appreciated because of expressing their own thoughts, views, and values**
P4.1.3a	The teacher shows her/his appreciation to learners who express their thoughts, views, and values

P4.1.3b	The teacher explains why expressing different thoughts, views, and values is significant in bioethics
P4.1.4	**The teacher assesses ethical issues through a multicultural perspective**
P4.1.4a	The teacher avoids relying on only a particular view when analyzing controversial ethical subjects
P4.1.4b	The teacher avoids imposing a particular view on learners when analyzing controversial ethical subjects
P4.1.4c	The teacher emphasizes the importance of supporting different thoughts, views, and values by reasonable moral justifications
P5	**Evaluation Standards**
P5.1	**Evaluation-Based Standards**
P5.1.1	**The teacher applies various evaluation methods**
P5.1.1a	The teacher utilizes assignments for grading learners
P5.1.1b	Besides assignments like reading, writing, case analysis, and presentation, the teacher give learners midterm and final exams
P5.1.2	**The teacher implements a fair grading system**
P5.1.2a	The teacher uses the grading to encourage learners to learn
P5.1.2b	The teacher gives learners the chance to fix the errors when they have assignments
P5.1.2c	The teacher rewards learners' good intentions and best efforts
P5.1.3	**The teacher gives learners timely and detailed feedback**
P5.1.3a	The teacher gives learners timely feedback

P5.1.3b	The teacher underscores the strengths and weaknesses of learner assignments
P5.1.3c	The teacher explains to learners how they can improve their assignments
P6	**Observation and Modification Standards**
P6.1	**Observation-Based Standards**
P6.1.1	**The teacher meticulously observes the effectiveness of applied teaching methods, content, approach, and evaluation system**
P6.1.1a	The teacher assesses the effects of teaching methods
P6.1.1b	The teacher observes the reactions of learners to the course content
P6.1.1c	The teacher evaluates the effectiveness of her/his teaching approach
P6.1.1d	The teacher appraises the relationship between learners' learning and the applied grading system
P6.1.2	**The teacher makes effort to understand the reason of ineffective applications**
P6.1.2a	The teacher asks learners for their evaluations about teaching methods, content, approach, and evaluation system
P6.1.2b	The teacher strives to comprehend whether the discovered or expressed shortcoming is the problem of some learners or a common one
P6.2	**Modification-Based Standards**
P6.2.1	**The teacher makes possible changes**

P6.2.1a	The teacher asks learners for their views about having some changes in ineffective areas
P6.2.1b	The teacher modifies ineffective points, if possible
P6.2.2	**The teacher notes ineffective areas to make changes in the future syllabi**
P6.2.2a	The teacher takes notes to modify her/his syllabus, if changes are associated with the syllabus
P6.2.2b	The teacher shares her/his thoughts regarding the changes with the administration
P6.2.3	**The teacher suggests recommendations to modify the curriculum**
P6.2.3a	The teacher examines the ineffective areas to figure out whether they are pertinent to the curriculum
P6.2.3b	The teacher submits her/his recommendations about changes in the curriculum to the administration
P6.2.3c	The teacher clarifies the reasons behind her/his recommendations

C- OUTCOMES

Code	**Standard-Indicator**
C1	**Ethical Knowledge**
C1.1	**Knowledge-Based Standards**
C1.1.1	**Learners show sufficient evidence that the bioethics course increases their ethical knowledge**

C1.1.1a	Learners demonstrate high performance in the exams
C1.1.1b	The writing assignment proves that learners have a clear understanding of the subject
C1.1.1c	The learner presentations illustrate that learners comprehend the subjects on which they presented
C1.1.1d	The case analysis assignments indicate that learners have adequate ethical knowledge to analyze ethical issues
C1.1.1e	Learners' responses to questions and discussions during the lectures reveal that learners have acquired ethical knowledge
C2	**Ethical Skill Standards**
C2.1	**Skills-Based Standards**
C2.1.1	**Learners demonstrate adequate evidence that the bioethics course improves their ethical skills**
C2.1.1a	The case analyses show that learners can identify ethical problems
C2.1.1b	The case analyses indicate that learners can apply their ethical knowledge to specific cases
C2.1.1c	The case analyses illustrate that learners can reflect different approaches to specific cases
C2.1.1d	The case analyses reveal that learners can explore certain ethical resolutions regarding specific cases
C3	**Ethical Behavior Standards**
C3.1	**Behavior-Based Standards**

C3.1.1	**Learners show some evidence that the bioethics course develops their ethical behavior**
C3.1.1a	The teacher's observations indicate that the bioethics teaching helps learners to avoid unethical behaviors
C3.1.1b	Learner interviews prove that the bioethics course decreases learners' unethical actions
C4	**Cultural Competence Standards**
C4.1	**Cultural Competence-Based Standards**
C4.1.1	**Learners illustrates certain evidence that the bioethics course promotes their cultural competence**
C4.1.1a	The case analyses prove that learners can recognize differences resulting from cultural, religious, or philosophical differences
C4.1.1b	The writing assignment and learner presentations demonstrate that learners can identify ethical challenges stemming from cultural, religious, or philosophical differences
C4.1.1c	The case analyses and assignments reveal that learners take cultural, religious, or philosophical differences into consideration during their analyses and the effort to find an ethical resolution
C4.1.1d	The teacher's observations illustrate that the bioethics course increases learners' awareness about cultural, religious, or philosophical differences

C4.1.1e	Learner interviews show that the bioethics course raises learners' perceptions concerning cultural, religious, or philosophical differences
C5	**Satisfaction Standards**
C5.1	**Satisfaction-Based Standards**
C5.1.1	**Learners are satisfied with taking the bioethics course**
C5.1.1a	Learners are satisfied with the relationship with the teacher
C5.1.1b	Learners are satisfied with the teaching approach
C5.1.1c	Learners are satisfied with the teaching content
C5.1.1d	Learners are satisfied with the teaching methods
C5.1.1e	Learners are satisfied with the knowledge and skills they obtain throughout the course

7 Chapter - Data Collection and Analysis Methods for Measuring the Indicators

7.1 Introduction

In the previous chapter, the standards and indicators of bioethics education were elaborated in accordance with the goals of bioethics teaching and the definition of quality in bioethics education. However, these determined indicators need specific data collection and interpretation to make a deduction regarding the fulfillment of the indicators and an overall quality a program. Avedis Donabedian describes data collection as "the life-blood of quality assessment" to emphasize the importance of data collection in quality evaluation.[1] This approach demonstrates that appropriate data collection and analysis is a crucial component of quality measurement. Furthermore, reliability and validity are essential considerations in the acceptability of conducting a research study and collecting data. In this view, regardless of how perfectly defining quality, determining goals, or formulating indicators, overlooking the significance of data collection and analysis may turn a whole quality evaluation process into a wasteful and time-consuming activity. Therefore, quality measurement or assessment should be established on a systematic research approach combined with an appropriate methodology for data collection and analysis.

From this perspective, the aim of this chapter is to succinctly examine research methods and data collection techniques to provide a descriptive example of data collection and analysis regarding the measurement of the indicators that were elucidated in the previous chapter. The chapter formulates a general framework about the data

collection and measurability of Quality in All Levels (QAL), rather than portraying a fully established research methodology, which can directly be determined by a researcher who desires to conduct a research based on QAL. In this view, the chapter begins with clarifying three research paradigms: quantitative, qualitative, and mixed research methods to show different data collection approaches. The second section looks at four major data collection techniques: document review, survey, interview, and observation. The third section appraises the quality of data by addressing the issue of reliability and validity. In the last section, data measurement and analysis is expounded in order to demonstrate how to interpret relevant information to reach a conclusion about the overall quality of a bioethics program.

7.2 Research Methods

In the previous chapter, the utilization of indicators in quality measurement was counted as the result of an evidence-based approach. However, applying such a method does not resolve all relevant problems per se. The issues of what evidence is, what to measure, and how to measure are some questions that should be expounded. Philip Davies states that in evidence-based education, "*What is evidence?"* is not the only question, but also, "*Which evidence is valid and reliable?"* is another substantial challenge.[2] In this view, indicators should possess the ability to demonstrate valid and reliable evidence of quality. S. M. Campbell et al. elucidate a similar question about what to measure by quality indicators in primary care. They assert that the answer depends on the determination of three different points: the perspective of which stakeholder should be taken into consideration, which dimension of care should be measured, and which research method should be used to gather information.[3] Campbell et al.'s perspective

shows that in some fields including healthcare and education, developing indicators is not an easy task due to the existence of several stakeholders and distinct aspects of services in these areas. Additionally, Campbell et al.'s third question identifies another challenge about indicators by mentioning the importance of research methods. From this perspective, in this section, different research methods will be detailed to clarify how pertinent information concerning indicators can be obtained.

7.2.1 Quantitative Research Paradigm

Donna M. Mertens defines the term *research* in education and psychology as "a process of *systematic inquiry* that is designed to collect, analyze, interpret, and use *data* to understand, describe, predict, or control an educational or psychological phenomenon or to empower individuals in such contexts."[4] This definition shows that research is not just any kind of data collection activity, but an organized investigation to obtain and assess information to figure out, delineate, and anticipate phenomena. In this context, the quantitative research paradigm is an approach that conducts this methodological inquiry in a quantitative manner. In other words, quantitative research is a method of information gathering and analyzing that employs numerical data and statistical correlations to explore objective and generalizable findings.[5] This research paradigm is grounded on the philosophical assumption that "a researcher can capture "reality" or "truth" within a certain level of probability" through numbers.[6] In light of this hypothesis, the quantitative method is a primary research methodology that is used not only in the natural sciences but also in the social and behavioral sciences.[7] The key characteristic of the quantitative approach is gathering facts regarding the research subject while maintaining the researcher's neutral stance and using a numerical language. This means that the explored

results are free from the researcher's bias or judgment.[8] In regard to medical ethics, survey research is a well-known quantitative approach used to view ethical issues and problems.[9]

Burke Johnson and Larry Christensen elaborate on the features of quantitative research and compare them with the attributes of qualitative and mixed research methods by using a comparison table. According to their specification, quantitative research has the following characteristics: the scientific method is comprised of deductive reasoning that uses top-down logic; the focus is narrow because the aim is only to test or confirm a particular hypothesis; the collected information consists of concrete numerical data that does not contain any intervention by the researcher; the data relies on variables and their objective observation; the data is analyzed through statistical correlations; the findings are generalizable because of the number of samples, the random selection of participants, and the less possibility of human biases; and the results are reported through certain mathematical techniques to illustrate "statistical significance of findings".[10] The essential role of the researcher in the quantitative approach is to determine variables, collect the data produced by the variables, and report the findings using a quantitative expression and statistical interpretation.

The quantitative research paradigm carries some strengths and weaknesses. In respect of the advantages of this research method, it can be stated that its capacity demonstrating statistical significances is the main asset of the quantitative methodology. The researcher's judgment- and bias-free position and research design give the opportunity to reach similar results under the same circumstances.[11] Furthermore, generating numerical information and using statistical analyses eliminates or decreases

vagueness of the collected data and its interpretation.[12] However, as emphasized in the previous section, the application of statistical correlation- or input-output relationship-based approaches in social and behavioral sciences, including education, is criticized due to the multidimensional facets of such disciplines, as well as the different perspectives on and expectations from these areas. For this reason, in social and behavioral sciences, mathematically formulated results and analyses can also be considered a disadvantage. Additionally, despite possessing particular principles and norms, certain academics fields, such as bioethics and education, demand taking individual needs, expectations, and differences into account. However, the specific hypothesis-testing, narrow focus of the quantitative method does not allow the researcher to analyze the depth of the subject adequately.[13] In this view, despite the favorable outcomes of quantitative research, like certainty, objectivity, and generalizability, the complexity and particular requirements of some research areas or subjects entail qualitative assessments that are subject to the researchers' judgments.

7.2.2 Qualitative Research Paradigm

Qualitative research is another method to collect, analyze, and interpret information to elucidate and comprehend phenomena. However, instead of relying on numerical data and statistical expressions, qualitative research utilizes a text-based and in-depth approach to comprehensively examine different aspects of a research area or subject. Due to its ability to analyze complex social phenomena, qualitative research is largely regarded as a more appropriate method than quantitative methods for grasping and explaining social and individual values, beliefs, and experiences.[14] According to Thorleif Lund, "[t]he qualitative approach developed partly as a protest against the

dominance of the quantitative tradition."[15] Anthony J. Onwuegbuzie and Nancy L. Leech describe this protest as a battle between interpretivist researchers and positivist researchers.[16] Both quantitative and qualitative research collect information to study and understand phenomena. Nevertheless, quantitative research counts on numerical data, while qualitative research relies on non-numerical data, such as observations and open-ended questions.[17] Therefore, the discussion between positivists and interpretivists is associated with the reliability and validity of numerical and non-numerical data.

As a common assumption, in comparison with the quantitative method, in the qualitative approach, the "researcher's value judgments and interpretations of the research" is more evident due to the researcher's impact on the researcher.[18] As Michael Quinn Patton underscores, "[t]he quality of qualitative data depends to a great extent on the methodological skill, sensitivity, and integrity of the researcher."[19] Therefore, the researcher has a prominent role in the qualitative methods and the success of the research. Pranee Liamputtong lists several reasons for carrying out the qualitative approaches in health and social sciences, some of which are as follows: qualitative research allows the researcher to hear silenced voices and empower research participants; complex issues require conducting a qualitative approach to explore details and discern problems; and it is essential to implement qualitative methods when developing theories to find out the needs, problems, and values of individuals and groups.[20]

Holly A. Taylor and her colleagues study the key characteristics of the qualitative methods under five categories: research focus, scope, research goals, source of data, and domains of analysis. The focus of qualitative approaches is on the content of values, beliefs, and attributes, rather than numerical measurements. These methods aim to

explore “truth” by investigating participants’ individual values and experiences. For this reason, the sources of data are chiefly participants and respondents. However, during data collection, the qualitative methods demonstrate a broad and holistic approach to gather details about the researched subject. Moreover, in respect of the domains of analysis, qualitative methods illustrate a flexible and dynamic design to shape the research in accordance with pertinent conditions, cases, and requirements.[21] Besides the mentioned features, it is important to underline the attributes of research results in qualitative methods. Contrary to the numerical findings of the quantitative method, qualitative results carry a higher potential to represent the researcher’s personal and subjective viewpoints.[22] However, this situation does not mean that the findings of qualitative research are unreliable or invalid. As expounded in the next section, distinct criteria must be applied in the case of assessing the reliability and validity in quantitative and qualitative research paradigms.[23]

Similar to quantitative research, the qualitative methods have certain advantages and disadvantages. Some academic fields including education and bioethics need to concentrate on individual, social, and cultural characteristics as well as the connection and interaction among them. Furthermore, in education and bioethics, the research subjects are human beings, and studying people’s attitudes, behaviors, and perceptions entails shedding light on their values and experiences using a holistic approach. Qualitative research provides the researcher the opportunity to comprehensively analyze all these issues without being restricted by numerical data and statistical methods. On the other hand, qualitative findings are more likely to contain the researcher’s personal viewpoints and unintentional biases. In this view, the possibility of the researcher’s

higher role and influence in the qualitative methods generates a direct correlation between the success of the research and the researcher's qualifications and experience.[24] Furthermore, despite showing various dimensions of investigated issues, qualitative results may not be generalized in the same manner of quantitative findings because the qualitative research "involves selecting a smaller, nonrandom, purposive sample of individuals who contribute to the generation of theories and hypothesis."[25] However, these challenges of the qualitative method may be alleviated by well-structured and well-conducted research designs, data collection, and data analysis. Nevertheless, many views recommend implementing mixed research methods to eliminate or reduce the disadvantages of quantitative and qualitative approaches and benefit from the advantages of both research paradigms.

7.2.3 Mixed Research Paradigm

The abovementioned strengths and weaknesses of quantitative and qualitative paradigms represent the benefits and drawbacks of a pure implementation of each research method. In other words, these consequences reveal the outcomes of pure quantitative and qualitative paradigms. Anthony J. Onwuegbuzie and Nancy L. Leech name the pure application of these research methods as "mono-method research" and consider this approach as "the biggest threat to the advancement of the social sciences."[26] According to Onwuegbuzie and Leech, mono-method proponents, which are also knowns as purists, believe that quantitative and qualitative research have fundamental distinctions in several aspects, hence these different research paradigms cannot be combined or used together.[27] However, many accept that quantitative and qualitative approaches can be mixed to avoid handicaps and take advantage of each research method.

The mixed research paradigm refers to integrating some characteristics of quantitative and qualitative research methods in a single study when conducting problem identification, data collection, data analysis, and final inference.[28] The mixed research paradigm is the opposite of mono-method research and does not limit the researcher to a single research paradigm. The decision about which features of quantitative and qualitative approaches should be combined or utilized depends on the requirements of the study and the researcher's study design.[29] In a mixed research-based study, the study may overwhelmingly carry the attributes of quantitative or qualitative paradigms or equally benefit from both approaches. In this view, the key point in mixed research methods is not to rely on merely a paradigm, but employ different characteristics of each approach in accordance with the study design and necessities of data collection and analysis.

Pure quantitative research chiefly reflects a narrow-focus to test a specific hypothesis, while pure qualitative research applies a holistic approach to study various aspects of the researched subject. In regard to this point, mixed research demonstrates a multidimensional and broad focus similar to qualitative research. The quantitative paradigm counts on numerical data and statistical explanations, whereas the qualitative paradigm banks on non-numerical information and narrative description. The mixed research paradigm can utilize quantitative and qualitative data and reporting techniques in the same study. This approach can eliminate the objectivity- and generalizability-related criticisms about the qualitative paradigm.[30] Therefore, it is possible to emphasize that mixed research method has the potential to benefit from the strengths of quantitative and qualitative research when considerably lessening the weaknesses of these two paradigms.

Education is a multi-faceted and sophisticated activity as it encompasses several stakeholders and different needs, perceptions, and expectations of each of them. Many scholars agree that the mixed research paradigm is the most appropriate method to study convoluted issues because of its ability to use all research tools and techniques to comprehend problems and generate answers to these problems.[31] Thorleif Lund reviews the literature on the assets of mixed research methods and summarizes them as follows:

> (1) Mixed methods research is more able to answer certain complex research questions than qualitative or quantitative research in isolation. For example, given that qualitative methods are more appropriate for hypothesis generation and quantitative methods for hypothesis testing, mixed methods enable the researcher better to simultaneously answer a combination of exploratory and confirmatory questions. Theory may therefore be generated and verified in the same investigation. As another example, in an intervention study, a randomized experimental design can be used for describing causal effects and a qualitative interview for explaining how these effects were generated. Hence, in one study, quantitative and qualitative methods can answer complex research questions related to both causal description and causal explanation.
> (2) Qualitative and quantitative results may relate to different objects or phenomena, but may be complementary to each other in mixed methods research. Hence, the combination of the different perspectives provided by qualitative and quantitative methods may produce a more complete picture of the domain under study.
> (3) Mixed methods research may provide more valid inferences. If the results from quite different strategies such as qualitative and quantitative ones converge, the validity of the corresponding inferences and conclusions will increase more than with convergence within each strategy.
> (4) In mixed methods research, qualitative and quantitative results may be divergent or contradictory, which can lead to extra reflection, revised hypothesis, and further research. Thus, given that data have been collected and analyzed correctly, such divergence can generate new theoretical insights.[32]

Furthermore, Burke Johnson and Larry Christensen use Yvonna S. Lincoln and Egon G. Guba's fishnet analogy to accentuate the benefit of mixed research methods.[33] According to this analogy, it does not matter how solid a fishing net is; because of its nature, the fishing net has holes and fish can escape the net through these holes. However, using overlapping fishing nets would fill the gap in the holes and would prevent the fish in the net from slipping away.[34] This analogy means that applying quantitative and qualitative approaches to a single study would alleviate the drawbacks of pure quantitative and qualitative research methods.

QAL examines quality in bioethics education through a comprehensive approach that sheds light on several components of the structure, process, and outcome and demands the effectiveness of all these levels. From this perspective, QAL proposes implementing an eclectic approach by utilizing the methods and techniques of both quantitative and qualitative research paradigms in data collection, data analysis, and reporting. The structure, process, and outcome indicators are measurable benchmarks of the model, and each indicator requires collecting specific data by utilizing at least one data collection method.

7.3 Data Collection

Due to the advantages of mixed research methods previously highlighted and the all-inclusive attributes of QAL, using both qualitative and quantitative approaches would be the most effective way to obtain the relevant information, analyze the data, and report the results. However, in respect of data collection, the pertinent methods should be elucidated to create a sturdy insight into the measurement of the indicators. In this context, in this section, the relevant data collecting methods will concisely be evaluated. Nevertheless, it should be underscored that instead of considering data collection techniques as only either pure quantitative or qualitative, acknowledging the transitivity between these methods would be a worthwhile approach because of the flexible link between quantitative and qualitative techniques as well as some practical benefits of mixed methods.[35] In other words, even though, at first glance, any data collection technique looks like pure qualitative or quantitative, the requirements of the study or the researcher's approach may convert it into another research paradigm or a mixed characteristic. Therefore, instead of labeling a data collection method as quantitative or

qualitative, shedding light on the implementation of each research and data collection technique separately would provide more accurate information regarding their features.

Moreover, it is essential to highlight two matters. First, only four major data collection methods are elucidated in this section. However, some other data collection techniques, such as standardized tests and secondary data, can be employed to obtain information about the indicators.[36] Second, more than one data collection method can be used when measuring an indicator. For example, in the case of evaluating the indicator, "*the teacher listens to learners about their needs, concerns, and expectation"*, surveys, interviews, and observations can simultaneously be utilized. Gathering information about the same indicator through different data collection techniques may even produce more favorable outcomes in respect of the reliability of the data.

7.3.1 Document Review

Document review is a primary data collection method that refers to obtaining information from any written, printed, or recorded materials including reports, forms, notes, online-files, films, and videos. Documents can be used directly as the main sources of data or supplements to other qualitative or quantitative information collecting sources.[37] Despite providing concrete information, documents are "mute evidence" entailing the researcher's interpretation.[38] This situation indicates an essential advantage as well as a disadvantage. The researcher only needs to access a document to collect information without disturbing any person or asking anyone for their personal thoughts, perceptions, or understandings. Therefore, obtaining a document may mean obtaining the information as well. However, legal and ethical concerns and restrictions about access to documents is a major flaw in this data collection method. Furthermore, in the case of

accepting a document as the sole source of information, the available document may cause an inaccurate and insufficient judgment.[39]

QAL contains numerous indicators that require examining documents to decide whether the criteria addressed by the indicator are fulfilled. For instance, "*the curriculum exists,"* "*the teacher has a relevant degree (at least a master's degree) in bioethics,"* and "*the syllabus defines expectations"* are some structure indicators that require documents to be reviewed to check whether the demanded requirements are met. Since the structure indicators assess the availability and adequacy of the inputs: curriculum, human resources, physical materials, physical facilities, and technological accommodations, the document review is a convenient method for collecting the structure measures-related information. It is also possible to encounter certain outcome indicators that necessitate looking at the pertinent documents to determine the actualization of outcomes, such as "*learners demonstrate high performance in the exams"* and "*the writing assignment proves that learners have a clear understanding of the subject."* Additionally, although the process indicators denote educational activities rather than inputs and outputs, document review and data collection methods can be applied to these indicators as well. For instance, examining the syllabus may provide significant information about certain components of the process measures, like teaching method, teaching scope, and evaluation.

7.3.2 Surveys

The survey method is an important data collection technique in social and behavioral sciences. Surveys, also known as questionnaires, contain certain questions or statements to "obtain information about the thoughts, feelings, attitudes, beliefs, values,

perceptions, personality, and behavioral intentions of research participants."[40] As Donna M. Mertens states, surveys are self-reporting sources about surveyed individuals' personal thoughts, judgments, and experiences.[41] Even though having certain quantitative characteristics, surveys can also be employed as data collection methods by other research paradigms including qualitative research.[42] Furthermore, surveys can be conducted with distinct advantages and disadvantages in various formats: mail, internet, telephone, and face-to-face surveys.[43] According to Floyd J. Fowler, Jr., there are four points influencing the success of surveys: first, "the size and representativeness of the sample from which data are collected;" second, "the techniques used for collecting the data;" third, "the quality of interviewing, if interviews are used;" and fourth, "the extent to which the questions are good measures."[44] Especially in the case of using samples, besides the validity of questions, the sample size and attributes of the chosen samples are crucial matters when seeking to precisely and thoroughly represent the pertinent population. Surveys denote individuals' personal opinions. However, representative samples carry the potential to demonstrate the general view of the whole relevant group. If a bioethics program consists of domestic and international students, choosing samples only from either domestic or international students may cause an inaccurate conclusion due to possible differences in their viewpoints or expectations. For this reason, sampling is a very important process in surveys, and samples must be representative to adequately reflect all pertinent groups that are subject to the research.

Surveys-based data collection is a major method to obtain information about the indicators. Surveys can be utilized to collect information about all components of QAL. For instance, in the event of gauging learners' satisfaction or evaluating the outcomes of

a bioethics course, surveys can be useful tools to explore learners' thoughts, experiences, and perceptions. However, surveys may play a bigger role in the assessment of the process indicators that chiefly illustrate learners' opinions regarding the teacher's approach and performance. For example, the indicators, "*the teacher listens to learners about their needs, concerns, and expectations,"* "*the teacher encourages learners to express their thoughts, views, and values,"* and "*the teacher tries to attract the learners' attention by asking questions during lectures"* request asking the learners whether these expectations are satisfied. However, this does not mean surveys are the only techniques to obtain data concerning the process measures; interviews and observations can also enable the researcher to gather data about the abovementioned indicators and other process indicators.

7.3.3 Interviews

Interview is another prominent data collection method having the ability to create a concrete insight into the researched subject by pinpointing individuals' thoughts, perceptions, and experiences in an interactive dialogue.[45] Norman K. Denzin and Yvonna S. Lincoln describe the interview as "the art of asking questions and listening," whereas Holly A. Taylor and her colleagues regard this data collection method as "a kind of conversation between a researcher and an informant."[46] A key feature of a successful interview is one in which the researcher is not simply a person who asks questions, but also a good listener who understands and interprets the interviewee's responses in their social context.[47] However, the researcher should also be meticulous to ensure and protect his/her neutrality throughout the interaction and conversation with the interviewee.[48] According to Andrea Fontana and James H. Frey, carrying out an interview is not as easy

as it seems, but it is the best way to comprehend human beings' views, feelings, perceptions, values, and experiences.[49] In general, interviews are classified under three categories in accordance with their formats: structured, semi-structured, and unstructured interviews. Structured interviews are the most basic forms containing fixed questions. On the other hand, unstructured interviews involve open-ended questions, and they are relatively burdensome in terms of their analyses and interpretations. Semi-structured interviews are mixed information obtaining methods encompassing predetermined questions while also giving the researcher or participant the chance to detail any question or express a relevant new issue.[50] In respect of participants, interviews are categorized as personal interviews and group interviews.[51] However, regardless of the kind of interview conducted in a research study, besides the general strengths and weaknesses of each type of interview, in the case of using samples, the size and characteristics of the samples are critical to the outcomes of this method, just as they are in surveys.

Due to the nature of bioethics education, which is defined as an ongoing transformative process, the interview can be one of the most appropriate methods to figure out teachers' and learners' views on the effectiveness of a course or program in bioethics. Interviews can be used to collect data about many indicators in all levels. For example, interviews can be very beneficial tools to appraise the interest of teachers and students in bioethics, as a component of the structure measures. Moreover, interviews can allow the researcher to gather in-depth data on the process indicators by inquiring into teachers' and learners' feelings, beliefs, and experiences. Additionally, this data collection technique can be applied to explore learners' satisfaction and perception about the impact of bioethics education on their ethical knowledge, skills, and behaviors.

7.3.4 Observations

Observation is another substantial technique to collect information in social and behavioral sciences. Contrary to survey and interview methods, observation is largely a pure qualitative data collection technique because of the researcher's role in obtaining and interpreting the data. This technique can be used as a primary or secondary data collection method; observing the behavior and reaction of students and the teacher in a classroom represents the former method, while observing the body language of a person during an interview denotes the latter technique.[52] Michael Quinn Patton counts observation as the best research method in studying complex social issues due to the opportunity of "direct participation in and observation of the phenomenon of interest."[53] Furthermore, examining people's behaviors through either a laboratory or naturalistic observation may produce more objective information because, unlike surveys and interviews, the researcher does not merely bank on participants' disclosures or sayings.[54] However, according to Burke Johnson and Lisa A. Turner, "[a] common problem of observation is reactivity, although reactivity may decrease significantly after the researcher has been observing for a while."[55] Reactivity refers to the change in the reaction and behavior of the observed persons as a result of knowing that they are being observed by the researcher.[56] However, the researcher can minimize this effect through a well-established research design.

Holly A. Taylor and her colleagues classify observations as participant and direct observations; in the former type, the researcher is an insider, while in the latter one, the researcher is an outsider.[57] QAL suggests a direct observation which gives the researcher a passive role in the observation without requiring the researchers' interference in the

observed field. Although it is possible to obtain a great deal of data about the indicators through surveys and/or interviews, an observation may enable the researcher to directly explore the research environment, the communication and interaction between the teachers and learners, the performance and interest of the teachers and learners, and the influence of bioethics education on the learners. Surveys and interviews rely on participants/respondents' personal views, feelings, and perceptions. However, as a third party and outsider, the researcher may gain more impartial information by observing the teachers and learners in their classroom environment. Furthermore, evaluating the impact of ethics education on learners' behavior is the most difficult aspect. Nevertheless, an observation with an adequate length of time may give the opportunity to mitigate this difficulty.

7.4 Quality of Data Collection

In the previous section, certain data collection methods were concisely examined in order to provide some hints about how the indicators-related data can be gathered. However, listing some data collection techniques or obtaining any pertinent information without looking at the quality of data may lead to a waste of time and resources spent on the research. In this context, it can be emphasized that an academically acceptable research study requires quality data, not just any data. Many studies explain the concept of *quality data* with J. M. Juran's definition of quality as "fitness for use."[58] For instance, Richard Y. Wang and Diane M. Strong describe data quality, from the data consumers' perspective, as "data that are fit for use by data consumers."[59] Similarly, Philip Woodall and his colleagues expound data quality for organizations through the same approach by using the statement "fit for use."[60] It can be concluded from these definitions that any

collected data in any organization or field must meet particular standards. Stephanie Watts, G. Shankaranarayanan, and Adir Even assess these standards in organizations through certain dimensions including accuracy, consistency, and relevance.[61]

In respect of data and research quality, Dave S. Collingridge and Edwin E. Gantt stipulate satisfying four standards: reliability, validity, sampling, and generalizability.[62] While expanding on surveys and interviews, in the previous section, the importance of sampling was briefly underscored. In regard to generalizability, it can be claimed that generalizability largely depends on reliability and validity. According to Laura D. Goodwin and William L. Goodwin, in qualitative research evaluation, reliability is a prerequisite to validity.[63] Furthermore, as Nahid Golafshani discusses, increasing the validity of qualitative research may increase the possibility of its generalizability as well.[64] In this view, especially in qualitative research, instead of counting generalizability as an independent dimension of data or research quality, accepting it as a dependent variable of reliability and validity would be more reasonable. Therefore, in this chapter, data quality is elucidated in light of reliability and validity with a focus on sampling and generalizability. From this perspective, QAL describes quality data as *the data that is reliable and valid*.

7.4.1 Reliability

Consistency, *stability*, and *repeatability* are basic terms commonly used to describe research reliability.[65] The key point of reliability is attaining stable results under the implementation of the same research methods and measurement criteria. Burke Johnson and Larry Christensen give the example of a scale to clarify the meaning of reliability. A scale must show the same weight for the same person. If a 125-pound

person steps on the scale five times and the scale reads 125, 124, 125, 125, and 126, it indicates that the results are reliable because the scale consistently gives similar results by repeating the same procedure. However, if the scale produces the weights 120, 130, 125, 135, and 115, it means that the measurements are unreliable because they are not stable.[66] In this context, reliability is a principal criterion for the acceptability of the collected data. However, according to Dave S. Collingridge and Edwin E. Gantt, reliability cannot be applied to quantitative and qualitative research with the same standards; reliability should be specified separately according to the research paradigm employed.[67] In light of Collingridge and Gantt's approach, the abovementioned description and example illustrate reliability in quantitative research; in the event of qualitative research, reliability is not expected to produce the same results repeatedly, but "consistent similarity in the quality of the results;" distinct results do not show unreliability as long as the research generates "rich and meaningful descriptions of phenomena."[68]

Donna M. Mertens highlights the significance of consistency in data collection instruments and the necessity of checking the reliability of these instruments using certain methods including repeated measures and internal consistency.[69] Nevertheless, it seems that Mertens' focus is chiefly on quantitative research, rather than qualitative research when appraising the reliability of data collection instruments. However, Laura D. Goodwin and William L. Goodwin discuss directly the application of reliability to qualitative research.[70] Although acknowledging the controversy surrounding reliability in the qualitative paradigm, they believe in the applicability of reliability to qualitative data collection by classifying reliability into four categories: interobserver reliability,

intraobserver reliability, stability, and internal consistency. In respect of data collection, *interobserver reliability* "refers to the extent of agreement or consistency among two or more independent observers;" *intraobserver reliability* denotes the consistency in utilizing the same data collection methods in a study and the consistency in obtaining the same by applying the methods; *stability* means to gain consistent information from the research subject when repeating the same data collection technique; and internal consistency represents "homogeneity in the approach, scheme, or schedule used."[71]

These approaches reveal that reliability in qualitative research should be differentiated from quantitative research. However, this difference does not mean that reliability is not applicable to qualitative research and its data collection techniques. On the contrary, reliability with its various interpretations should be taken into consideration to ensure the quality of research and data in the qualitative research paradigm as well. Nevertheless, in comparison to quantitative research, in qualitative research, the researcher needs to be more vigilant throughout the research about using suitable data collection instruments in order to fulfill the requirements of reliability. In this view, due to many qualitative characteristics of data collection techniques in QAL, the researcher who conducts a QAL-based study should be aware of the distinct understandings of reliability and should notice the importance of data quality from a reliability-related perspective.

7.4.2 Validity

Validity is another essential standard for determining the quality and acceptability of research and data. Reliability is the precondition of validity, which means that prior to evaluating the validity of the data, the reliability of the data must be affirmed. In other

words, reliability is a prerequisite for gauging validity.[72] Validity is associated with the issue of whether the obtained data is the data that the researcher is looking for.[73] In regard to validity, if a researcher wants to evaluate the knowledge students acquired from a course, the collected data must carry the ability to demonstrate the level of knowledge, such as exam results. Therefore, "[v]alidity is a scale's ability to measure what it sets out to measure."[74] In respect of the example of the scale explained above, if the person desires to measure his/her weight, a reliable scale would be an appropriate tool and the results would be valid. However, using the same scale when the person wishes to measure his/her height would give invalid results because the scale does not measure the person's height, but their weight. In this case, even though the results are reliable, they are invalid due to the irrelevance to the measuring point.

Unlike reliability, validity has a similar understanding in both quantitative and qualitative research.[75] However, different authors classify the types of validity into different categories, such as content, construct, convergent, criterion-related, concurrent, and consequential.[76] Nevertheless, the forms of validity most used are content, construct, and criterion validity. Content validity in data collection looks at the issue of "the extent to which the data collection strategy (observation, interviewing, record review) provides for a representative sampling of times, events, persons, or settings".[77] Construct validity refers to the extent to which data collection instruments measure a theoretical construct.[78] Criterion validity denotes "the strength of the relationship between our measurement tools [data collection methods] and other measures of the same phenomenon."[79]

In data collection, reliability is mostly related to the quality of the data, such as its accuracy, consistency, and repeatability, whereas validity is largely associated with data

collection instruments and their utilization. Therefore, reliability and validity have different functions, but they are complementary to each other. In this context, in the case of data collection about the indicators, appropriate methods should be chosen to ensure the measurability of the indicators.

7.5 Data Measurement and Analysis

As briefly accentuated above, data collection is an essential matter not only in QAL, but in all research studies. The overall reliability and validity of the research are directly associated with the reliability and validity of the collected data. However, quality data can be turned into a meaningful form through appropriate analysis and interpretation. In other words, the quality of the data is necessary but not sufficient to fulfill the quality of the research. The collected data should be converted into a measurable fashion to facilitate its analysis. In this view, non-numerical data can be translated into numerical data. Quantitizing is such a method, denoting the transformation of qualitative expressions into quantitative figures.[80] In the implementation of QAL, a Likert scale-oriented approach with a variable coefficient-based evaluation can be applied to the data regarding each indicator in order to express the quality of the indicators with numbers and combine all the indicators to reach a conclusion about each measurement level (structure, process, and outcome).

7.5.1 Likert Scale

The Likert scale, which was developed by Rensis Likert in 1932, is a rating method frequently used in surveys by many disciplines including social science, education, and healthcare.[81] The primary attribute of the Likert scale is restricting the number of responses. A classic Likert scale sequences responses in a 5-scale category

format in order of their favorability, such as *strongly agree*, *agree*, *neutral (or neither agree nor disagree)*, *disagree*, *strongly disagree* or *never*, *seldom*, *sometimes*, *often*, and *always*. However, due to the ambiguity in the use of *neutral*, the 5-scale category format can be reduced to a 4-scale one.[82] Furthermore, according to Gail M. Sullivan and Anthony R. Artino Jr., despite giving each response a number sequentially from 1 to 5, which presumes equality between responses, using a 5-scale response does not mean that "the difference between responses is equidistant."[83] Moreover, the difference between certain responses may lead to some confusion. For instance, in the event of employing the *strongly agree*, *agree*, *neutral*, *disagree*, and *strongly disagree* response categories, besides the problem with the use of *neutral (or neither agree nor disagree)*, the distinction between *agree* and *strongly agree* or *disagree* and *strongly disagree* may not be clear for all respondents.

Nevertheless, despite encompassing such disadvantages, the Likert scale is a method which is beneficial and frequently used to convert responses into measurable formats. Additionally, the Likert scale is a technique that rates responses using certain scale and response categories that are determined by the researcher.[84] In other words, the Likert scale has the flexibility to allow the researcher to design scales and response categories in accordance with the research conditions. As some studies prove, the number of scale points, such as a 5-point Likert scale or a 10-point Likert scale, does not significantly influence the reliability and validity of the research; it is possible to achieve reliability and validity with any number of scale points.[85]

As mentioned above, the Likert scale is a common rating instrument in surveys. Robert A. Pearlman and Helene E. Starks classify the data collected by surveys into three

levels of measurement: nominal data, ordinal data, and interval data, and describe the Likert scale as an ordinal data-based scale that demonstrates "the strength of the response to a statement."[86] In the case of comparing QAL indicators with these considerations, it can be said that QAL does not only utilize surveys, but also documents reviews, interviews, and observations. However, almost all the indicators can be gauged with ordinal data. For this reason, a Likert scale-based measurement can be implemented with all the indicators of the structure, process, and outcome, regardless of data collection techniques. This method would create the opportunity to transform qualitative statements or findings into numerical expressions by rating them using a scale of a certain number. For instance, the researcher can utilize any data collection technique to measure the indicator "*The teacher shows sufficient effort to understand learners needs, concerns, and expectations*." At the end of the data collection process, the researcher should reach a conclusion about the satisfaction level of this indicator. Instead of addressing the conclusion with words, like "the teacher is approachable and makes a lot of effort to figure out the challenges the students experience," the researcher should utilize a number from 1 to 5 (in the case of employing a 5-point Likert scale, such as strongly agree, agree, neither agree nor disagree, disagree, strongly disagree) in order to illustrate the satisfaction level of the indicator numerically. Moreover, it is important to note that in the event of document reviews, interviews, and observations, it is the researcher rating the collected information and responses in light of the determined scale points. This situation may eliminate or significantly reduce the ambiguity related to the scale points. As an expert in research, the researcher can efficiently match the available data with the scale points. For example; during an interview, students would articulate their thoughts about

the indicator "*the teacher shows sufficient effort to understand learners needs, concerns, and expectations"* in the way their express themselves. However, it would be the researcher transforming the students' statements into a number based on the used Likert scale point.

7.5.2 Ranking Indicators

The analytic hierarchy process (AHP), which was developed by Thomas L. Saaty, is a decision-making model used to ascertain the most favorable decision by comparing and rating available alternatives.[87] This ranking model has been utilized by many scholars in various disciplines to analyze and prioritize existing decision options.[88] The AHP aims to allow the making of a good decision in any area about any issue. The importance of the existence of this model to QAL is that it proves that available alternatives can be systematically compared and ranked. Furthermore, in respect of performance indicators, Peter J. Harris and Marco Mongiello discuss the matter of ranking indicators to detect key indicators in hotel management.[89] In this view, a ranking system can be used to analyze QAL indicators as well. Nevertheless, the recommended ranking approach should be employed as an additional feature to the Likert scale assessment.

QAL formulates structure, process, and outcome indicators through main category standards, sub-category standards, and standards. There are many indicators in each category. However, the importance of an indicator in a standard; the importance of a standard in a sub-category; the importance of a sub-category in a main category; and the importance of a main category in a level (structure, process, and outcome) may differ considerably according to the ad hoc situation, needs, expectations, or perspective of the educational institution or researcher. For this reason, the weight of each of the indicators,

standards, sub-category standards, and main category standards should be determined separately by using some coefficients in a Likert scale-based evaluation.

QAL suggests a three-degree ranking, as "important," "very important," and "extremely important," (TDR) to decide the significance of each indicator, standard, sub-category standard, and main category standard by comparing them with the same group indicators, standards, sub-category standards, and main category standards. The option "important" denotes the coefficient 1, "very important" addresses the coefficient 2, and "extremely important" refers to the coefficient 3. These coefficients can be applied to all the indicators, standards, sub-category standards, and main category standards in order to determine the categorical importance of a component in its own group. For instance; "*P1.1.1a-The teacher listens to learners about their needs, concerns, and expectations*" and "*P1.1.1b- The teacher shows sufficient effort to understand learners needs, concerns, and expectations*" are two indicators of the standard "P1.1.1- *The teacher demonstrates the willingness to build an effective communication with learners*" in the communication-based standards. If the researcher thinks that the indicator P1.1.1b is more important than P1.1.1a to decide whether the teacher demonstrates the willingness to build an effective communication with learners, the researcher can employ these coefficients to differ the importance of the indicator P1.1.1b from the indicator P1.1.1a.

7.6 Conclusion

This chapter focused on research methods and data collection techniques to delineate the data collection and analysis of QAL. The chapter describes research as an organized investigation to obtain and assess information to understand, analyze, and anticipate phenomena. Due to certain disadvantages of pure research paradigms, the

present chapter proposes the utilization of a mixed research method by integrating some attributes of both quantitative and qualitative paradigms in a single study. In this context, document reviews, surveys, interviews, and observations can be utilized as data collection methods in QAL. However, it is important to note that more than one technique can be used to collect data regarding an indicator. The quality of data, which was elucidated by reliability and validity, is another crucial matter to which the researcher should attribute sufficient attention when conducting research and collecting data.

QAL recommends benefitting from the Likert scale and implementing a Likert scale-oriented approach to all the indicators in order to convert qualitative data into numerical statements. Additionally, the utilization of the TDR is encouraged to differentiate the weight of an indicator, standard, sub-category standard, and main category standard in its own group assessment. Aside from all these descriptive clarifications, it is acknowledged that the methodology of research should be decided by the researcher directly. As a normative model, QAL does not dictate a predetermined or strict methodology. However, in this chapter, a general framework regarding data collection and analysis was drawn to provide some clues about the formulation of QAL. If a researcher wishes to test this model, he/she can determine his/her own research design without an obligation to completely follow the data collection techniques and analysis examined in this chapter.

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8 Chapter - Conclusion

Bioethics education has remarkably grown across the globe in the last few decades. Even though it may be difficult to declare the exact number of the current bioethics institutions and programs, the data of the UNESCO Global Ethics Observatory proves that bioethics education is a global phenomenon with various bioethics institutions, teaching programs, and academicians.[1] Additionally, the Kennedy Institute of Ethics lists 45 bioethics journals in English and 12 non-English bioethics journals.[2] Although the list may not illustrate bioethics journals in all languages and all countries, the given list of journals demonstrates the level of academic growth in bioethics. However, this situation does not mean that bioethics education has reached a stable and flawless level.

In a recent publication, *Global Education in Bioethics*, Henk ten Have accentuates sundry challenges in the current bioethics education. Firstly, we do not know what is the impact of recruiting adjunct faculty and providing online courses (instead of hiring permanent qualified professors and having face-to-face classroom-based courses) on bioethics education; these two matters may decline the foreseen benefits of bioethics teaching. Secondly, even though authorities and policymakers acknowledge the significance of ethics education to prevent professional misconducts and ensure good practices, in many countries, adequate bioethics education, “in terms of volume, time, and commitment,” is not provided. Thirdly, as a widespread global problem, bioethics is taught by instructors who do not have a sturdy academic career and background in

bioethics. Finally, bioethics education represents a too heterogeneous field without an explicit agreement on the content, goals, and methods of bioethics teaching.[3]

The issues emphasized by ten Have are congruent with the findings of the literature review elaborated in the first chapter of this dissertation. The literature review reveals that both educators and students admit that ethics education is an effective way to increase students' ethical awareness, knowledge, and reasoning. Nevertheless, the reviewed literature does not demonstrate a consensus on the content, scope, and method of ethics education. On the other hand, all the pertinent parties agree on the need for more ethics education. Moreover, the review shows that the lack of required and separate ethics courses as well as the insufficient length of courses are essential barriers in ethics education. Additionally, the shortage of educators and educators' qualifications are some other challenges negatively impacting the performance and effectiveness of ethics education.

Even though the literature review provides certain clues regarding educators' and students' perception about the effectiveness, performance, and shortcomings of ethics courses, it is not clear how the relevant parties understand and interpret the concept of quality in ethics education. None of the reviewed articles explicitly gives adequate indications to be able to define and specify quality or to be able to draw a general framework regarding quality standards and indicators in ethics education. For filling this gap, this dissertation aimed to propose a model to define and measure quality in bioethics education. The dissertation reflected its approach to quality in bioethics education through 8 chapters including the introduction and conclusion by displaying certain findings about the current situation of ethics programs, specifying the goals of bioethics

education, analyzing the concept of quality according to the main characteristics of bioethics education, determining particular quality standards and indicators, and elaborating data collection methods and techniques. The model proposed by this dissertation is called *Quality in All Levels* (QAL) to highlight the necessity of certain standards in all levels of bioethics education.

After an overview of the dissertation in the first chapter (introduction), the second chapter elucidated the literature review of 34 scholarly articles to pinpoint the current situation in the teaching of ethics and figure out whether there were any indications of what quality in ethics education is. The findings of the review exhibited certain conclusions. Firstly, ethics education carries a positive influence to improve ethical awareness, knowledge, and judgment. Secondly, the lack of required and stand-alone ethics courses, the length of courses, and qualified educators diminish the possible benefits of ethics education. Thirdly, students largely prefer having an ethical principles/codes-based and case-driven teaching model. Finally, in respect to quality in ethics education, the review did not generate promising outcomes to explore how quality is defined or evaluated. Nevertheless, the literature review provided invaluable hints regarding students' and educators' perceptions and expectations as well as the performance, shortages, and shortcomings of ethics programs and gave the opportunity to build the subsequent chapters on these manifestations.

The third chapter shortly examined the history of bioethics and bioethics education to inquire about the historical background of medical ethics and developments in bioethics education. The chapter evaluated the pre-bioethics time under three periods: the Hippocratic Oath, Galen ethics, and Thomas Percival's medical ethics. The chapter

considered bioethics an evolutionary change and paradigm shift in medical ethics. In other words, even though the significance of political, medical, technological, and legal occurrences and developments, in the post-World War II period, on the emergence of bioethics was admitted, the chapter assessed bioethics as a result of the evolutionary process in medical ethics. Additionally, the chapter recognized Fritz Jahr as the person who first utilized the term *bioethics* in German in 1927 and accepted Van Rensselaer Potter as the person who first used this word in English in 1970. The chapter also displayed the striking growth of bioethics education along with the mushrooming of bioethics in the last five decades. The chapter expounded that bioethics centers, such as the Hastings Center and Kennedy Institute of Ethics, international organizations, like UNESCO, and political initiatives, such as the presidential commissions in the United States have remarkably affected the dissemination of bioethical values, rules, and principles, as well as the flourishing of bioethics education.

The fourth chapter focused on the goals of bioethics education to illuminate the issue of why bioethics is taught. Enumerating the goals and explaining the reasoning behind each goal also paved the way for interpreting quality in bioethics education in the fifth chapter. The fourth chapter integrated Kohlberg's cognitive-developmental approach, Handelsman et al.'s ethical acculturation model, and the Delors Report's learning throughout life concept to formulate the goals of bioethics education. The cognitive-developmental approach refers to the role of educators in teaching bioethics and requires giving learners the opportunity to obtain information about all the aspects, ideas, and approaches of bioethics without imposing any specific one on learners. The ethical acculturation model denotes learners' position in bioethics learning and demands

integrating learners' individual preexisting moral values with their professional requirements. The learning throughout life concept regards bioethics education as an ongoing transformative process and necessitates a continuous learning course throughout practicing a profession. Furthermore, the four pillars of the Delors Report were taken into consideration to decide the goals of bioethics education. In this context, the chapter determined the goals as: increasing ethical knowledge as learning to know, improving ethical skills to strengthen ethical sensitivity, awareness, and judgment as learning to do, developing ethical behavior as learning to be, and promoting cultural competence as learning to live together.

The fifth chapter shed light on the notion of quality and analyzed this concept through certain approaches from some other fields to define quality in bioethics education. This chapter had a key function to create a connection between the previous and subsequent chapters by utilizing the goals of bioethics education to describe quality and then shaping quality standards and indicators in accordance with this definition. The arguments about the concept and understanding of quality revealed that due to various stakeholders of products or services, it is not an easy task to explore a definition of quality to meet the distinct needs, perceptions, and expectations of all these stakeholders. However, in respect of bioethics education, the chapter concluded that describing quality in light of the goals of bioethics teaching may be the most appropriate way to ensure a functional, objective, and measurable definition. From this perspective, quality in bioethics education was defined as conformance to the goals. This approach regards quality in bioethics education as an ongoing transformative process to increase ethical knowledge, improve ethical sensitivity, awareness, and judgment, develop ethical

behavior, and promote cultural competence. The chapter considered this definition functional due to exhibiting some practical purposes, such as increasing ethical knowledge; it deemed the definition as objective because of emphasizing the significance of cultural competence, instead of relying on specific beliefs, values, or principles coming from certain cultural, religious, or philosophical backgrounds; and the chapter accepted the definition as measurable due to encompassing quantifiable criteria.

The sixth chapter formulated quality standards and indicators to establish measurable benchmarks in order to gauge quality in bioethics education. The chapter adapted Donabedian's three approaches—structure, process, and outcome— as three levels in bioethics education. The QAL model analyzed the structure through 5 categories: curriculum, human resources, physical materials, physical facilities, and technological accommodations. The process was classified as communication, teaching methods, teaching scope, teaching approach, evaluation, and observation and modification. The outcome was specified as ethical knowledge, ethical skills, ethical behavior, cultural competence, and satisfaction. These main categories of the structure, process, and outcome were detailed through specific standards and indicators as listed in the appendix. According to QAL, the ultimate quantifiable point is the indicators, which refer to the transformation of the standards into specific and measurable criteria. On the other hand, standards are defined as general requirements or expectations regarding the attributes of the structure, process, and outcome to measure quality in these areas. In this context, QAL applies an inductive approach, which means that in the case of a QAL-based study, the researcher must follow a path from the indicators to the standards, from the standards to the main categories, and from the main categories to the levels.

The seventh chapter investigated data collection and data analysis methods and techniques to elucidate the measurability of the indicators as well as the general functioning of QAL. The chapter advised the utilization of a mixed research method because of the intention to avoid the drawbacks of pure research paradigms and take the advantages of both quantitative and qualitative methods. In this view, QAL recognizes document reviews, surveys, interviews, and observations as primary data collection techniques. Moreover, QAL underscores the importance of reliability and validity to guarantee data quality and research credibility. QAL also proposes using the Likert scale to transform qualitative statements into numerical data during data collection and analysis. Furthermore, for prioritizing the weight of indicators, standards, and main categories in their own classifications, the QAL model suggests employing a three-degree ranking (TDR) as important, very important, and extremely important with the coefficient 1 for important, coefficient 2 for very important, and coefficient 3 for extremely important indicators, standards, and main categories.

As a result, QAL is a model defining and measuring quality in bioethics education with the objective of filling the gap in this emerging field. Revisiting the goals of bioethics education and determining the four goals in accordance with Kohlberg's cognitive-developmental approach, Handelsman et al.'s ethical acculturation model, and the Delors Report's learning throughout life concept is an essential characteristic of this dissertation. Even though all the goals are equally substantial to fulfill the expectations of bioethics teaching, the dissertation underlines the significance of promoting cultural competence to be able to live together, regardless of individuals' and societies' distinct cultural, religious, political, or philosophical values. Additionally, the dissertation

denotes the first endeavor comprehensively inquiring the connection between bioethics education and quality as well as the first work defining quality in bioethics education. In this view, QAL assesses bioethics education as an ongoing transformative process and regards quality as conformance to the goals.

QAL benefits from Avedis Donabedian's structure, process, and outcome approach to form functional, objective, and measurable quality standards and indicators. QAL relies on mixed research methods and different data collection techniques including document reviews, surveys, interviews, and observations. Furthermore, a Likert scale-driven approach and an analytic hierarchy process are recommended to analyze data and draw a conclusion about the overall quality of a bioethics program or course. QAL does not merely measure quality according to outcomes, but also equally values the effectiveness of the structure and processes. This approach means that long-standing, deliberate, and sustainable quality can only be achieved by simultaneously reaching certain standards in all the three levels: structure, process, and outcome; otherwise, even in the event of favorable outcomes, the presence of these outcomes would be short-term, accidental, and unsustainable. For this reason, QAL implies that the establishment and maintenance of quality require the effectiveness, integration, and collaboration of all the levels.

On the other hand, it is possible to express some limitations of QAL. Firstly, QAL is a normative model, and without implementing this model to an actual study, it may be difficult to estimate the shortcomings of the model. Secondly, QAL assumes that all stakeholders of bioethics education agree on the determined four goals. However, particular needs, perceptions, or expectations of the stakeholders may lead to the

reinterpretation of the goals. Additionally, QAL considers the four goals equally crucial, but the requirements of a program or course, the mission of the institution, or the expectancies of a stakeholder could entail attributing more importance to certain goals. Thirdly, even though the proposed standards and indicators were formulated by benefiting from the pertinent literature, the specific objectives, needs, and conditions of educational institutions might request revisiting these standards and indicators. In the event of a QAL-oriented study, the researcher could modify the standards and indicators in accordance with the research design and institutional priorities. Finally, QAL indicates a general framework concerning data collection and data analysis, rather than illustrating a fully established research methodology. For this reason, the details of the research methodology should be decided by the researcher, in the case of carrying out a QAL-driven study.

Endnotes

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